Abertay University

Certification

Pharmacy Technician Regulation and Professionalism: a Discourse Analytic Study

by

Carol Nairn, BSc

A thesis submitted in partial fulfilment of the requirements of the Award of

Doctor of Philosophy

April 2015

I certify that this is a true and accurate version of the thesis approved by the examiners, and that all relevant ordinance regulations have been fulfilled.

Signed Principal Supervisor: …….. Date: .....

Declaration

I, Carol Nairn, hereby declare that this thesis is my own original work and has not been submitted elsewhere in fulfilment of the requirement of any other award. Where information has been derived from other sources, I can confirm that this has been indicated in the thesis.

Signed …… Date: …….

Table of Contents

The appendices are provided in a separate bound volume.

List of Tables

List of Figures

List of Appendices

Dedication

This thesis is dedicated to my Dad, Charlie Jamieson, who regularly asked if I "wasn't finished yet" and alleged that I "must surely be pretty clever by now" with his customary cheeky smile. I have missed him with his quiet loving ways and great sense of humour over the latter phase of writing this thesis.

Acknowledgements

There are a number of people who have supported me throughout this study to whom I wish to express my grateful thanks.

The pharmacy technicians and pharmacists who gave up their time to be interviewed, and without whom this study would not have been possible.

Dr Jim Moir, my academic supervisor for his guidance, support, encouragement, understanding and patience regarding my perfectionist tendencies over the years.

Dr Gordon MacLaren, Dr Baxter Millar and Andrew Radley, my work place supervisors who, with their different approaches and wisdom, managed to be challenging, motivating and enjoyable at the same time.

My work colleagues for their ongoing support and understanding.

And last but most definitely not least, my family and friends; they have been unwavering in their tolerance and thoughtfulness throughout and I look forward to spending more time with them.

Abstract

Background: This research explored regulation and professionalism with respect to the current state of professional practice for hospital pharmacy technicians. Since July 2011 pharmacy technicians must register with the General Pharmaceutical Council in order to practise. An acknowledged benefit of registration is professional recognition; however there is a lack of published research about pharmacy technicians' professionalism with no study found that offers a holistic exploration post mandatory registration.
Method: This study utilised a broad discourse analytic approach to examine *how* pharmacy practitioners talk about the pharmacy technician role, regulation and professionalism, being sensitive to the content of these accounts but also the ways in which they are constructed and the varying rhetorical effects and power. The sociology of the professions provided the theoretical background for this study to examine the notion of professionalism in modern healthcare and whether or not pharmacy technicians are enabled to undertake the professional practice for which they are now accountable. Data were gathered through interviews with pharmacy technicians, pharmacists and Directors of Pharmacy, which were digitally recorded and transcribed prior to discourse analysis.
Findings: The findings illuminate gaps in the professional socialisation of pharmacy technicians related to 1) Policy: a lack of appropriate conditions and opportunities for pharmacy technicians to demonstrate professional practice and contribute to current policy implementation, 2) Practice: pharmacy technicians do not have the supportive infrastructure to enable their own professional practice or carry out research, and 3) Education and Training: current qualifications are traditionalistic and not fit for purpose.
Discussion: Recommendations are made in relation to these three concerns, including: development of pharmacy technician practice to take responsibility for the supply chain of medicines; review organisational structures, roles and discourses to enable this clear division of labour; the Association of Pharmacy Technicians UK promotes the development of a 'Scope of Professional Practice for Pharmacy Technicians' to support practice development and clarify accountabilities, and improves promotion of pharmacy technician research activity; and finally, review the content and level of pharmacy technician pre- and post-registration qualifications to address identified gaps and to support a structured career pathway. Findings from this study have already been transferred into practice in terms of: development of national recruitment guidance; establishment of a 'Professionalism Programme' for all local pharmacy staff; development of terms of reference for a local pharmacy technician professional forum to enable professional development and leadership; and, the initiation of discussions to develop a national pharmacy technician professional forum in Scotland.

Abbreviations

APTUK	Association of Pharmacy Technicians United Kingdom
CPD	Continuing Professional Development
GPhC	General Pharmaceutical Council
NES	NHS Education Scotland
NAPS	National Acute Pharmacy Services Group
RPS	Royal Pharmaceutical Society
RPSGB	Royal Pharmaceutical Society of Great Britain

Glossary

TERM	DEFINITION	REFERENCE
Discourse	All forms of spoken interaction, formal and informal, and written texts of all kinds.	Potter and Wetherell 1987, p.7.
Discourse analysis	Focuses on talk and texts as social practices and on the resources that are drawn upon to enable those practices.	Potter 1996a, p.129.
Profession	A distinct and generic category of occupation work.	Evetts 2012, p.2.
Professionalism	An occupational or normative value, as something worth preserving and promoting in work and by and for workers.	Evetts 2012, p.3.
Professionalisation	The process to achieve the status of a profession.	Evetts 2012, p.3.

1 INTRODUCTION

The focus of this thesis is on the regulation and professionalism of hospital pharmacy technicians in Scotland. This introductory chapter provides: a brief background to the study; an overview of the research focus and approach; information on the researcher; and finally an explanation of how the thesis is structured.

1.1 Background

In 2000 the government made clear its intention to regulate healthcare staff working with patients but "who do not have a professional qualification", including pharmacy technicians (Great Britain. Department of Health 2000a, p.85). Pharmacy technicians work primarily in community pharmacy and hospital pharmacy, increasingly in patient-facing roles. In July 2011, it became mandatory for pharmacy technicians to be registered with, and therefore regulated by, the General Pharmaceutical Council (GPhC) in order to practise (Anon. 2009). Whilst the purpose of regulation is to "... promote the health, safety and well-being of users of health and social care services and the public" (Professional Standards Authority for Health and Social Care [no date]), the GPhC claims that a benefit of registration for pharmacy technicians is professional recognition (Nicholls 2010).

Whilst there is a proliferation of studies on professionalism, it has recently been acknowledged that there is a lack of research regarding pharmacy

technicians and professionalism (Elvey et al. 2011; Elvey, Hassell and Hall 2013; Schafheutle et al. 2012). Furthermore, of the partially relevant research that has been carried out (Bradley et al. 2013; Middleton 2007; Schafheutle et al. 2012), none has offered a holistic exploration post-mandatory registration and none has been carried out by a pharmacy technician.

1.2 Research Focus and Approach

As an 'insider' and a pharmacy technician in a leadership role I have been, and continue to be, immersed in the professionalisation of the pharmacy technician workforce both at a local and national level. As a witness to the deliberations around pharmacy technician regulation throughout my career, I was interested in the notion of 'professional recognition': if one is recognised as a professional, in return there is an expectation that one will behave as a professional. Indeed Duncan Rudkin (2013, p.3), the Chief Executive of the GPhC, calls for pharmacy technicians to "focus on professionalism" in the best interests of patients. But what is a professional and how is professionalism constructed in modern healthcare? Are pharmacy technicians equipped and enabled to undertake professional practice? If not, what recommendations can be made in order to facilitate patient-centred professionalism for pharmacy technicians? These issues are explored by drawing upon conceptual analyses from the sociology of the professions in order to examine how pharmacy practitioners, that is pharmacy technicians and pharmacists, construct aspects of professionalism.

The research questions for this study are:

I. How do pharmacy practitioners present pharmacy technicians in relation to contemporary professionalism characteristics?

II. How do pharmacy practitioners account for roles and future practice development in light of pharmacy technician regulation?

These research questions require a qualitative research approach that is able to collect and analyse *how* pharmacists and pharmacy technicians talk about the pharmacy technician role, regulation and professionalism. In other words, the approach adopted needs to be sensitive to not only the content of these accounts but also the ways in which they are constructed and their varying rhetorical effects and power. With this in mind, the methodological approach to this study is discourse analysis, an umbrella term for a social constructionist approach to the study of language. Discourse analysis does not consider language as representative of what people 'think' but instead, that people construct versions in a variety of ways depending on its function and the context within which it is being used (Gill 1996).

With mandatory registration a recent phenomenon for pharmacy technicians, this study is a timely piece of work, which may also of be of interest to other newly regulated professions seeking to make recommendations that will enable the provision of patient-centred professionalism.

1.3 Researcher Personal History and Motivations

It is good practice within the qualitative research tradition that the researcher discloses his/her personal history and motivations for the choice of research topic, as well as disclosure of orientation (Morrow 2005; Stiles 1993; Taylor 2001a). Thus in this section I provide information on my background, relevant experiences and interests that led to the present study, and briefly describe the development of my research skills and interest in discourse analysis. In the Methodology Chapter of this thesis I present a specific section (3.8) on reflexivity, where I disclose my known orientations, assumptions, expectations and potential biases that I bring to the research before going on to describe the efforts I took to manage these subjectivities.

To commence with my background: I started student pharmacy technician training in 1981, qualifying as a pharmacy technician in 1983. Since then I have held a variety of posts in hospitals as a rotational pharmacy technician, junior manager from 1991, senior manager since 2002, and latterly as the Pharmacy Manager of a hospital pharmacy service and Head of Medicines Supply Chain for the Health Board within which I work.

Since working at a senior manager level I have been a pharmacy technician in a pharmacists' world, sometimes feeling a lone and unpopular voice, which has not always been easy. I have faced challenges and challenging experiences at a local and national level in Scotland, both with regards to my own role and the pharmacy technician role in general. Whilst my employers

have demonstrated vision and encouragement in appointing a pharmacy technician to senior level posts (my current and previous posts), the focus at a senior level in pharmacy is still primarily on pharmacists although this is certainly improving. I considered that the regulation of pharmacy technicians, and the consequent rhetoric of professional recognition and its implications, provides a potential opportunity to change this unequal relationship and shift towards there being two complementary pharmacy professions. It was always my aim that this research would have a practical application; I was not doing it simply as an academic exercise but with a desire to give something useful to the NHS, the pharmacist profession and the pharmacy technician profession in particular.

Regarding my research skills to undertake this study: in addition to supervisory sessions and extensive reading of the literature, I undertook a Masters level module on 'The principles, methods and practice of research methods'. However it was a module I completed on 'Conversation analysis and discourse analysis' that introduced me to the world of language as social action and in doing so, provided me with a completely new perspective with which to explore pharmacy technician regulation and professionalism.

The current section has provided an overview of my personal history and motivations, and highlighted a shift in my epistemological and ontological orientations which are discussed in more detail in the Reflexivity Section in the Methodology Chapter (Section 3.8).

1.4 Thesis Structure

This thesis is set out as follows: Chapter 2 presents the literature review, charting the development of the hospital pharmacy technician role in the United Kingdom as a consequence of National Health Service (NHS) reforms as well as the legislative and regulatory changes that led to the registration of pharmacy technicians with the GPhC. There follows an overview of the sociology of the professions as the theoretical touchstone for the study, and then a critical review of the empirical literature. The chapter concludes by drawing together these discussions in order to offer a rationale for the study as presented.

Chapter 3 sets out the methodology used for this study, commencing with an explanation of the research approach taken and a justification for this, prior to outlining the perceived limitations of this approach. The methods for developing the research questions are then presented, followed by details of the research participants, the sampling framework and the methods used for data collection and data analysis. There follows an explanation of ethical considerations and a penultimate section on researcher reflexivity, with the chapter then concluding with a section on warrantability in relation to discourse analysis.

The findings presented in Chapter 4 comprise the analysis and discussion; eight different aspects of professionalism are presented, each set out with an introduction, analysis with data excerpts, a discussion and summary.

The fifth and final chapter sets out the conclusions along with recommendations made as a result of this study. It commences with an introduction briefly outlining the background and rationale for the study, the sociology of the professions conceptual framework and the methodology. Next the findings are situated in relation to social constructionist assumptions prior to providing a synthesis of the key findings with regards to the two main research questions. A section on theoretical implications highlights how this study contributes to the current knowledge base, followed by policy, practice and education implications. Here, the transfer of findings into practice that has already happened as a result of this research is reported, followed by further recommendations to enable professional practice for pharmacy technicians. There follows a reflective section outlining what went well with this research and what lessons I have learned, and then the limitations of the study are expressed. The chapter concludes with recommendations for future research and an overall conclusion.

2 LITERATURE REVIEW

2.1 Introduction

This chapter commences with a review of the policy, practice and theoretical literature in relation to pharmacy and the regulation of pharmacy technicians. First a brief history of pharmacy in the United Kingdom and the origins of the pharmacy technician role are described. There follows a description of the modernisation of hospital pharmacy, which identifies how legislation and National Health Service (NHS) reforms have impacted upon the roles and responsibilities of hospital pharmacists and pharmacy technicians. Thereafter, government led changes to the regulation of healthcare staff and the primary reasons for these are highlighted. These regulatory changes, along with the development of the pharmacy technician role, led to the regulation of pharmacy technicians, the main aspects of which are then outlined. According to the Royal Pharmaceutical Society of Great Britain (Anon. 2009) and the GPhC (Nicholls 2010) regulation brings professional recognition and therefore the sociology of the professions forms the theoretical framework for this study. The section on the sociology of the professions commences with the rise of the professions, followed by an overview of the main theories of the professions and finishing with an exploration of contemporary professionalism. This section is concluded with a summary of the theoretical, practice and policy literature review. Next, a critical review of the relevant empirical literature is presented followed by a summary, the conclusion and finally the justification for this study.

2.2 A History of Pharmacy and the Origins of the Pharmacy Technician

Pharmacy can trace its roots back as far as 4000BC to the country now known as Iraq where plants were used to compound medicines; there is also evidence of this in China and Egypt from around 2000BC (Royal Pharmaceutical Society [no date] a). In Britain, the Society of Apothecaries, which was established in the mid 16th century, instituted the apothecary's monopoly over dispensing prescriptions and the physician's monopoly over prescribing (Taylor, Nettleton and Harding 2003). Around the same time, 'druggists' were members of the Company of Grocers with the right to sell drugs, and dispensing chemists dispensed medicines in physicians' dispensaries. Hence there were three occupations engaged in the preparation and dispensing of medicines: apothecaries, druggists and dispensing chemists (Taylor, Nettleton and Harding 2003).

In 1841 the Pharmaceutical Society of Great Britain was established, becoming the Royal Pharmaceutical Society of Great Britain (RPSGB) in 1988 when it was granted Royal status by the Queen (Royal Pharmaceutical Society [no date] b). The Pharmaceutical Society aimed to unite apothecaries, druggists and dispensing chemists into one profession, to represent their interests and to advance knowledge (Royal Pharmaceutical Society [no date] b). The 1868 Pharmacy Act established a register of people who could compound, dispense and sell 'poisons' and in 1908 the Poisons and Pharmacy Act introduced the title 'pharmacist' for all registrants (Royal Pharmaceutical Society [no date] b). In the 1933 Pharmacy and Poisons Act,

anyone involved in the sale or dispensing of certain medicines was required to be registered with the Pharmaceutical Society (Taylor, Nettleton and Harding 2003).

Whilst the history of pharmacy and pharmacists is quite well documented, there is little in the literature about the history of pharmacy technicians per se. Knipe (2009) claims that pharmacy technicians have their roots in the 1815 Apothecaries Act, which allowed qualification as an 'assistant to an apothecary'. Knipe (2009) also asserts that the RPSGB still offered a qualification of 'dispensing technician' up until 1985 when it was superseded by the Business and Technology Education Council (BTEC) qualification (in England). An email received from Nicholas Wood, the Curator of the Society of Apothecaries, on 2nd June 2014, offers consensus regarding pharmacy technicians having their roots in the 1815 Apothecaries Act; however the latter point regarding the qualification is disputed. The Curator purports that the dispensing technician qualification was available through the Society of Apothecaries, not the RPSGB, and it was available until 1998 when it was largely superseded by the competency-based National Vocational Qualification (NVQ) for pharmacy technicians. The Curator also points out that there were other recognised qualifications available, for example through City and Guilds, Boots and the National Pharmaceutical Association. Lastly, the Curator considers that the title 'technician' was one that gradually replaced the term 'dispenser' and that this came about because 'technician' was a term used for other occupations in the hospital service and it implied someone worthy of a better career and pay grade than a 'mere' dispenser.

He adds that at the time, many thought this change in title was pretentious. However the title ‘technician’ continued to be used and technicians were working in hospital pharmacies in the 1970s when the role of the hospital pharmacist began its shift towards clinical pharmacy.

2.3 Modernisation of Hospital Pharmacy

In the 1970s hospital pharmacy’s focus was on compounding and dispensing medicines with minimal direct patient contact (Taylor, Nettleton and Harding 2003). Since the publication of the Noel Hall Report in 1970 (Great Britain. Working Party on the Hospital Pharmaceutical Service), which advocated the development of clinical roles for pharmacists, there has been a number of strategic documents promoting pharmacists’ clinical role. The findings from the Committee of Inquiry into Pharmacy, more commonly known as the Nuffield Inquiry (Nuffield Committee of Inquiry into Pharmacy 1986), were acknowledged as “a watershed in the historical development of pharmacy in the UK and were a precursor to many subsequent developments” (Taylor, Nettleton and Harding 2003, p.2). Further, the Nuffield Inquiry is recognised as the catalyst for the development of the HNC in Pharmaceutical Sciences delivered by Telford College in Edinburgh from 1991 to develop pharmacy technicians’ managerial and clinical skills in order to release pharmacists for clinical roles (Scottish Qualifications Authority 2013).

After the Nuffield Inquiry, other key drivers in the development of clinical pharmacy in Scotland included the Scottish Health Management Efficiency

Group (SCOTMEG) Project on Clinical Pharmacy Services (Scottish Office 1994), 'Pharmacy in a New Age' (Royal Pharmaceutical Society of Great Britain 1996), 'Pharmacy in the Future: Implementing the NHS Plan' (Great Britain. Department of Health 2000b); 'A Spoonful of Sugar' (Audit Commission 2001); 'The Right Medicine: A Strategy for Pharmaceutical Care in Scotland' (Scottish Executive 2002); and, 'Prescription for Excellence: a Vision and Action Plan for the Right Pharmaceutical Care through Integrated Partnerships and Innovation' (Scottish Government 2013a). There remains a requirement for compounding and dispensing medicines but in the 21st century the tasks associated with these functions are largely carried out by pharmacy technicians and pharmacy support workers, whilst pharmacists' roles have developed to input directly into patient care, providing a clinical service on wards as part of the multidisciplinary team. Whilst the aforementioned strategic documents have all contributed to the development of clinical pharmacy, in the early 2000s the key driver for this shift in division of labour in hospital pharmacy was 'The Right Medicine: A Strategy for Pharmaceutical Care in Scotland' (Scottish Executive 2002). 'The Right Medicine' demanded that pharmacists' roles developed on the wards to provide care to patients and to achieve this, pharmacy technicians were to take on roles traditionally undertaken by pharmacists. This strategy also required the assessment of patients' own medicines when patients came into hospital and the development of one-stop dispensing. Patients' own medicines are assessed so that they can be re-used in hospital to minimise waste and reduce errors. One-stop dispensing is the provision of dispensed medicines for individual patients to be used during their in-patient stay and

then on discharge, the intention being to reduce delays and waste at discharge. Funding from the then Scottish Executive enabled pharmacy technicians to start working on the wards to carry out the assessment of patients' own medicines and to implement one-stop dispensing.

At the same time more pharmacy technicians began to qualify as pharmacy dispensary checking technicians, which permitted them to carry out the final accuracy check on dispensed medicines, and pharmacy technicians also took on management roles thereby further releasing pharmacists to provide a clinical pharmacy service. The use of robotics and a drive for an economical skill mix have further developed the pharmacy technician role in some hospitals to take on more clinical activities such as documenting accurate medication histories and counselling patients on their medicines at discharge. The recent publication of 'Prescription for Excellence' (Scottish Government 2013a) will require these 'extended' roles for pharmacy technicians to become widespread and common-place. Moreover, this strategy requires that all pharmacists become independent prescribers providing person-centred pharmaceutical care in new models of practice. 'Prescription for Excellence' therefore requires pharmacy technicians to be responsible for the supply chain of medicines, making best use of their knowledge and skills, and thus providing an excellent opportunity for the pharmacy technician profession.

2.4 NHS Reforms and the Regulation of Healthcare Professions

Since the establishment of the NHS in 1948 the organisation and management of healthcare, along with the roles carried out and the expectations of the public, have changed greatly. This section charts these NHS reforms and describes the drivers for improvements to the regulation of healthcare staff.

In the early theories of the professions there were different schools of thought regarding government control. The service orientation of professionals was emphasised by T H Marshall in 1939, who claimed that government control of the professions would "threaten the very essence of professionalism" (p.158-159 quoted in Johnson 1972, p.13). In contrast the economists amongst the social scientists doubted the espoused benefits of professionalism and instead perceived professional organisations as bureaucracies enabling monopolistic practices (Johnson 1972).

During the 1970s the rising doubts over the altruistic notions of professionalism, along with the shift towards 'client rights', led to an increase in the government's role in regulation (Eraut 1994). The election of Margaret Thatcher as Prime Minister in 1979 brought about major changes in the organisation of the NHS. Thatcher was sceptical about healthcare professionals' service orientation rhetoric and believed that professions were actually interested in occupational control, not purely driven by altruism (Harrison and Pollitt 1994). In the 1980s the lack of resources in conjunction

with the right-wing perception that better management of the NHS, learning from the private sector, would improve efficiency and help to control the self interest and independence of the professions led to the Griffiths Report and the introduction of general managers in the NHS (Harrison and Pollitt 1994). These strategies employed by the Conservative government in its management of the NHS resulted in a demoralised workforce and, more importantly according to Harrison and Pollitt (1994), a public disquiet with the NHS. As a result there were further reforms in the NHS during the 1990s, with an emphasis on cultural change and quality in an effort to reassure the public and improve staff morale (Harrison and Pollitt 1994). Moreover these reforms provided the opening for managers to better understand areas of professional practice and therefore influence professional judgement through the use of "management style quality programmes" which impacted upon professional autonomy (Harrison and Pollitt 1994, p.11).

The introduction of more hierarchical organisational structures, standardisation of work through evidence-based practice and the development of protocols and guidelines, e.g. Scottish Intercollegiate Guidelines Network (SIGN), generated a further shift towards decreasing professional autonomy (Coyler 2004). The quality agenda renewed the focus on improved services to patients, supported by John Major's 'Citizen's Charter', reinvigorating the patient-centred notion of healthcare (Harrison and Pollitt 1994).

Amidst this background serious cases which highlighted concerns with patient safety and regulation, such as Beverley Allit (Great Britain. Department of Health 1994), Harold Shipman (The Shipman Inquiry 2005) and the Kennedy report of the public inquiry into children's heart surgery at Bristol Royal Infirmary (Great Britain. Department of Health 2001), the government made plans to regulate healthcare staff whose work directly impacted upon patient care (Great Britain. Department of Health 2000a). In addition the public were increasingly sceptical about self-regulation and collegiality being used to protect colleagues ahead of concerns for patient safety.

The publication of the White Paper 'Trust, Assurance and Safety – The regulation of Health Professionals in the 21st Century' reformed the regulation of health professionals in Great Britain (Great Britain. Department of Health 2007). This White Paper brought about changes including: the assurance that professional regulators were independent; the development of systems for revalidation; and, that any concerns over practice were dealt with appropriately. The White Paper also enabled legislative changes to the Council for Healthcare Regulatory Excellence, now known as The Professional Standards Authority, which oversees the work of healthcare regulatory bodies, to make it an independent, more strategic council with a statutory requirement to incorporate stakeholder views. Moreover, the White Paper recommended the regulation of emerging healthcare professions.

2.5 The Regulation of Pharmacy Technicians

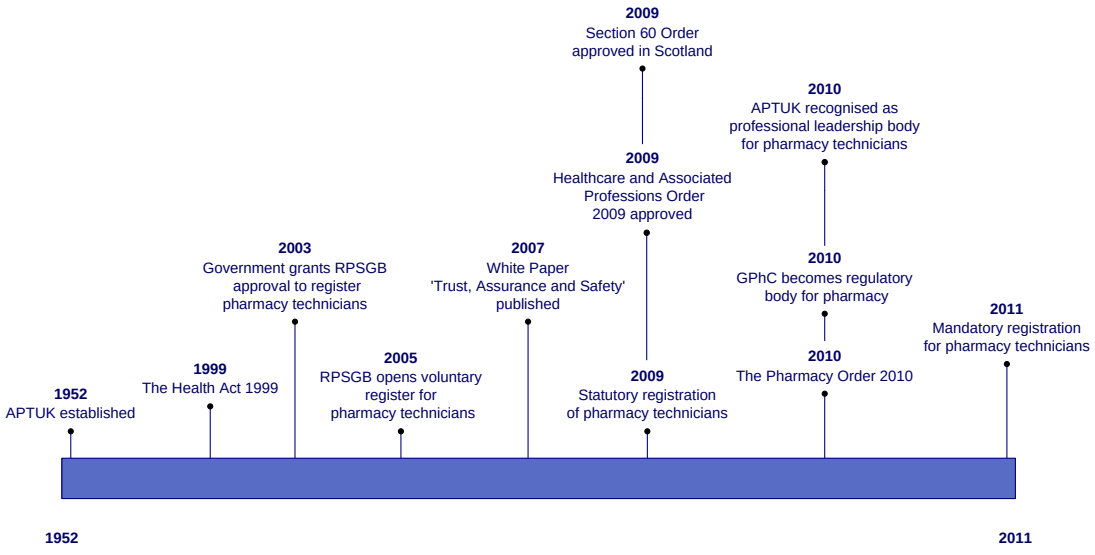
As described in Section 2.3, the modernisation of hospital pharmacy, since the early 21st century pharmacy technicians have been carrying out many roles traditionally undertaken by pharmacists, who have been a registered profession since 1933 (Taylor, Nettleton and Harding 2003). The Association of Pharmacy Technicians UK (APTUK) ([no date] a) has been calling for registration of pharmacy technicians since its inception in 1952. The Health Act (1999) permitted regulatory bodies to regulate professional support staff without the need for primary legislation (Hockey 2014) but it was not until 2003 that the RPSGB decided that it wished to register pharmacy technicians and that it should be the regulatory body (Royal Pharmaceutical Society of Great Britain 2003). This decision was not without its critics, for example Community Pharmacy Scotland (Anon. 2008), the National Pharmaceutical Association (Anon. 2002) and the former Secretary and Registrar of the Royal Pharmaceutical Society of Great Britain (Ferguson 1999), were opposed to registering pharmacy technicians on the grounds that it was not necessary to deliver high quality patient care. Nonetheless a voluntary register for pharmacy technicians opened in 2005 and by the end of 2005 just over 2000 pharmacy technicians had registered (Leech 2006).

A protracted process through the legislation, complicated by the devolution of healthcare to the Northern Irish and Welsh assemblies and the Scottish Parliament in 1999, finally resulted in the statutory registration of pharmacy technicians with the RPSGB from July 2009 with mandatory registration

imposed from 1st July 2011 (Anon. 2009). This allowed for a 'grandparent' transitional period of two years to allow those who had not voluntarily registered time to register, and also for those who did not hold the specific entry qualifications to register if their current qualification and work experience met the transitional standards (Anon. 2009). The Pharmacy Order 2010 enabled the regulatory and leadership functions previously held by the RPSGB to be split and a new regulatory body for pharmacy be established: the General Pharmaceutical Council (John 2014). The RPSGB continued as the professional leadership body for pharmacists although in 2010 it became known as the Royal Pharmaceutical Society (RPS), and the Association of Pharmacy Technicians UK (APTUK) became the recognised leadership body for pharmacy technicians.

The timeline for regulation of pharmacy technicians is illustrated in Figure 2-1.

Figure 2-1 Timeline for pharmacy technician regulation



The RPSGB (Anon. 2009), on gaining approval to register pharmacy technicians, cited professional recognition as a benefit of registration and this continues to be a benefit espoused by the current regulator, the GPhC (Nicholls 2010). Thus pharmacy technicians gained professional status in the eyes of the regulator but what does it mean to be a professional and a member of a profession? In an attempt to answer these questions there follows an overview of the sociology of the professions.

2.6 Sociology of the Professions

Oxford Dictionaries (2013) defines a profession as:

> *A paid occupation, especially one that involves prolonged training and a formal qualification.*

This simple definition is to some extent at odds with the extensive literature on the professions, where one thing commentators do agree upon is that definitions of professionalism abound and that it is a complex concept to describe (e.g. Hammer 2000; Southon and Braithwaite 2000; Van de Camp et al. 2004). However, throughout the different theories postulated in the sociology of the professions, one characteristic that is common amongst them is the requirement for a qualification based on specialised knowledge, usually as a result of lengthy training. Thus the Oxford Dictionaries definition, although simple, captures an aspect of professionalism that has endured since the concept of the professions emerged.

Evetts (2012) defines three concepts commonly used within the sociology of the professions, namely: profession; professionalisation; and professionalism. Evetts (2012) describes a profession as representing "... a distinct and generic category of occupation work" (p.2); professionalisation as "the process to achieve the status of profession" (p.3); and, professionalism as "an occupational or normative value, as something worth preserving and promoting in work and by and for workers" (p.3).

The following section outlines the rise of the professions before presenting a brief history of the main sociological schools of thought regarding the professions and professionalism, that is: trait theory; power theory; professionalisation; concluding with concepts of professionalism in a contemporary NHS.

2.6.1 The Rise of the Professions

Law, medicine and the clergy are acknowledged as the first of the professions as early as medieval times, when learned men used their esoteric knowledge for the goodness of the community in return for privileged status and reward (Hilton and Slotnick 2005; Larson 1977). This trinity continued as the recognised professions up until the 19th century Industrial Revolution, when there was a rapid expansion in the number of occupations and professional organisations that sought professional status such as engineers and accountants (Johnson 1972; Larson 1977). About the same time formal

training and examination were acknowledged as the key to legitimate the competency of professionals (Larson 1977).

The early 20th century saw the rise of 'modern' professionalism and the emergence of the ideology of professionalism. The first studies of the professions were carried out by Carr-Saunders and Wilson in their 1933 book 'The Professional' (Traulsen and Bissell 2004), and Talcott Parsons in 1939 with his seminal paper 'The professions and the social structure' (Taylor, Nettleton and Harding 2003). These works were functionalist, developing Emile Durkheim's functionalist theory that the professions provide a valuable contribution to the function of society, upholding moral order through their professional ethics (Johnson 1972; Macdonald 1995). Parsons (1939, p.457) claimed that "it seems evident that many of the most important features of our society are to a considerable extent dependent on the smooth functioning of the professions". He also maintained that the professions have a service orientation and are not oriented by self interest. These themes are continued in further early studies of the professions which are, in the main, highly uncritical, with professionals seen in a positive light, being inherently virtuous and moral beings motivated by the common good (Cruess, Cruess and Johnston 2000; Johnson 1972; Macdonald 1995; Traulsen and Bissell 2004). The functionalist theory relied on professions being defined by certain attributes or traits, and this trait approach to professionalism is now considered in more detail.

2.6.2 The Trait Approach

The trait approach is rooted in the concept that professions display certain traits, attributes or characteristics that define them as a profession and separate them from other occupations. Sociologists within this field attempted to list the attributes that defined professions against which occupations could be assessed (Macdonald 1995); this resulted in the identification of a large range of attributes with no consensus amongst the trait theorists on those that are fundamental to define a profession (Johnson 1972; Macdonald 1995; Witz 1992). Despite this, Millerson identified the following characteristics that were most commonly mentioned: a theoretical knowledge base; provision of education and training; competence tested; a professional organisation; a code of conduct; and, altruism (1964, p.15, cited in Johnson 1972, p.23). Johnson (1972) goes on to claim that autonomy is also an important characteristic. More recently Cruess, Cruess and Johnston (2000) referred to four common characteristics of a profession identified in the literature, namely: specialised knowledge and control over its use and teaching; altruism; autonomy; and, integrity and development of knowledge through research. Other commentators (e.g. Traulsen and Bissell 2004; Weiss-Gal and Welbourne 2008) listed further variations of the 'common' attributes, although a systematic body of knowledge appears to always be included.

Based on the trait approach, Amitai Etzioni (1969) coined the term 'the semi-professions' to describe occupations such as teachers and nurses, his argument being that these were occupations within bureaucratic organisations

that have less autonomy, and that they do not require a specialised body of knowledge therefore requiring less training than ‘true’ professions. Furthermore, these occupations do not have the level of professional status held by the ‘true’ professions such as doctors and lawyers. Etzioni (1969) claimed that occupations seeking professional status may do so to differentiate themselves from ‘non-professionals’ such as administrators and secretaries but that this endeavour for professionalism is unlikely to be met. Factors involved include that the ‘semi-professions’ are predominantly female and that they do not meet the two traits that Etzioni claims are characteristic of ‘true’ professions: the knowledge base and the ideal of service. The ‘semi-professions’ may also accept that they do not ‘deserve’ professional status and fear “rejection by those who hold the status legitimately” (Etzioni 1969, p.vii). He suggested that ‘semi-professions’ should instead aim for a middle ground and be satisfied with the notion of ‘semi-professionalism’.

Criticisms of the trait approach include: it is based on the established professions such as law and medicine with no consideration of cultural, economic or political differences related to emerging professions (Eraut 1994; Johnson 1972; Larson 1977); the range of attributes identified by the various sociologists and the lack of agreement on those that are required (Johnson 1972; Traulsen and Bissell 2004; Witz 1992); and, the lack of a theoretical framework and thus theory is open to researcher bias, with researchers able to select the attributes that best substantiate their hypothesis (Johnson 1972). Larson (1977) also criticised the lack of explicitness in the trait definitions, for example: the lack of specifics related to ‘lengthy training’ and the level of

‘specialised knowledge’; that service orientation is another loose characteristic; and that there is a lack of evidence to support the assertion that professions are somehow more ethical. In response to these criticisms a new theory emerged in the 1960s which is referred to in the sociology of the professions literature as the power approach.

2.6.3 The Power Approach

Fundamental assumptions within the power approach include: professions have a monopoly over their training and in the marketplace (Macdonald 1995; Saks 1999; Traulsen and Bissell 2004); professional position is used for self-interest and dominance over other occupations resulting in high status, a privileged position and economic reward (Johnson 1972; Larson 1977; Macdonald 1995); and that professions use strategies and techniques to develop and maintain dominant positions in the face of threats from other occupations, government and employers (Macdonald 1995).

Terence Johnson, Eliot Freidson and Magali Larson were pivotal in the change of focus in the studies of the professions from the positive perspective associated with the functionalist and trait approaches to a more sceptical view and a concern with power relationships. Within the power approach writers placed a different emphasis in their studies. Johnson (1972), in the Marxist tradition, centred on professions’ control over autonomy being related to producer-consumer relationships: the larger the ‘social distance’ the more control and greater need of the professional’s skills by the client.

Professionalism, as well as defining an occupation, is described as an institutional form of control. Johnson claimed that "variations in the role of governments and academic organisations will substantially affect the control and institutional forms associated with similar occupational activities" (1972, p.29-30). Thus there is no single or consistent route to professional recognition, instead professionalisation is culture bound, and the type of institutional occupational control is a crucial factor in this process. Whilst he argued vehemently against trait theory, Johnson (1972) conceded that professional ideology includes expert practice as an essential tenet, and that research is a key aspect of professionalism, within constraints that the research is non-threatening to the occupation's place in society and within the occupation's dominant group. Eraut (1994) purported that the difference here with trait theorists is how research is or should be controlled.

Neo-Weberian perspectives within the power approach centre on a variety of strategies used to gain occupational control. Freidson (1970) focused on autonomy and dominance, and particularly how medics gained, developed and maintained formal control of other healthcare workers in the division of labour. Another important aspect of Freidson's (1970) work centred on the knowledge/power nexus and he claimed that specialised knowledge, and control over this knowledge, was vital for professionalism. Larson (1977) also focused on market power and construction of an abstract knowledge as professionalisation strategies. Her 'professional project' theory explained in 'The Rise of Professionalism' was based on, and developed, Freidson's work, and is acknowledged as significant in the sociology of the professions

(Macdonald 1995). Larson (1977) was interested in the strategies and techniques used by 'modern' professions to gain, maintain and increase power and market control, and the relationship between market control and the negotiation of cognitive exclusivity enabling practical application of a relatively abstract body of knowledge. This control of the market for professional expertise is used to acquire and sustain professions' privileged position.

Anne Witz picked up some of Larson's work in 'Professions and Patriarchy' (1992), focusing on gender and the employment of closure strategies by professions to mobilise power in their endeavour to attain and maintain "an occupational monopoly over the provision of certain skills and competencies in a market for services" (p.5). Witz (1992) described four closure strategies which she developed from the work of Parkin, Murphy and Freidson, these being defined as follows:

Exclusionary closure: involves a "downwards exercise of power in a process of subordination" (p.45) where the aim is "intra-occupation control over the internal affairs of and access to the ranks of a particular occupation group" (p.44) and a concern with "the supply of an occupational group's own labour and creating a monopoly of skills and knowledge" (p.46).

Inclusionary closure: "the upwards, countervailing exercise of power by a social group which is hit by exclusionary strategies, but which, in its turn,

seeks inclusion within the structure of positions from which its members are collectively debarred" (p.48).

Demarcationary closure: "creation and control of boundaries between occupations" (p.46) i.e. inter-occupational control by dominant occupations which "aim for inter-occupational control over the affairs of related or adjacent occupations in a division of labour" (p.44).

Dual closure: these are more complex strategies but defined as "they entail the upwards countervailing exercise of power in the form of resistance on the part of subordinate occupational groups to the demarcationary strategies of dominant groups, but they also seek to consolidate their own position with division of labour by employing exclusionary strategies themselves" (p.48).

Exclusionary and demarcationary strategies are used by dominant groups in an attempt to maintain and develop occupational closure; inclusionary and dual closure strategies are used by subordinate groups in an effort to gain occupational closure. Within the dual closure strategy subordinate groups employ usurpation and exclusion tactics simultaneously. In her study of inter-occupational relations between midwives and doctors, Witz (1992) described how midwives engaged dual closure strategies in their professional project. The first being exclusionary closure, whereby education and registration restricted access to the occupation. The second being usurpationary, however within this strategy there was a split with one group of midwives taking a revolutionary stance and the other an accommodating stance. The

revolutionary stance involved a demand for a broad knowledge base, increased scope of competence, including the use of instruments for child birth, and a system of registration that provided independent professional status. This approach promoted autonomy for midwives and opposed subordination by medics. The accommodating stance involved an acceptance of the limited role demanded by medics and therefore a limited knowledge base, a narrow scope of practice, and a registration system that was controlled by medics. This approach complied with medics' demarcationary strategy to de-skill midwives but also meant that the midwife occupation continued as opposed to medics taking on all aspects of childbirth and therefore disposing of the midwife role.

Further terms used in professional projects, and seen as closure strategies, are 'legalistic' and 'credentialist' tactics. Witz (1992) defined legalistic tactics as "an attempt to gain a legal monopoly through licensure by the state" (p. 65), and credentialist tactics as the "use of educational certificate and accreditation to monitor and restrict access to occupational positions" (p.64). Witz (1992, p.58) also referred to Larson's use of 'autonomous' and 'heteronomous' in relation to professionalisation, with autonomous referring to "the means which are defined or created to a significant extent by professional groups themselves" and heteronomous as "those [means] which are chiefly defined or formed through other social groups".

According to Macdonald (1995), criticisms over the power approach include the lack of acknowledgement of the broader social structure. Macdonald

(1995) also claimed that whilst Johnson's work is often referred to in empirical terms, his typology is rarely acted upon.

Associated with the power approach and occupational closure strategies is the concept of professionalisation.

2.6.4 Professionalisation

Evetts defines professionalisation as "the process to achieve the status of a profession" (2012, p.3). This view of professionalisation as a process that occupations undertake to arrive at an end state of a profession is a perspective also taken by Wilensky (1964, pp.137-157 cited in Johnson 1972, p.22), who described professionalisation as a process with five steps in which the following characteristics are achieved: a full time occupation emerges; establishment of a training or education programme; a professional association is formed; a code of ethics is developed; and lastly, legal sanction and the protection of title. Other commentators offer more abstract definitions of this process to professionalisation whereby an occupation demonstrates certain characteristics that are considered essential for professional recognition based on the functionalist and trait models of professionalism (Johnson 1972) which were discussed earlier in this chapter. The issue regarding a lack of consensus on these 'essential' characteristics is a criticism of this perspective (Johnson 1972).

Another perspective on professionalisation is that of occupational control; rather than a profession possessing certain characteristics, occupations use different strategies dependent upon their position in an attempt to gain, maintain or develop occupational control. Witz's (1992) closure strategies discussed in the previous section of this chapter (2.6.3) fit within this perspective, as does Larson's 'professional project'. Larson (1977) defines professionalisation as:

> *an attempt to translate one order of scarce resources – special knowledge and skills – into another – social and economic rewards. To maintain scarcity implies a tendency to monopoly: monopoly of expertise in the market, monopoly of status in a system of stratification.* (p.xvii)

Macdonald (1995) provides an example of a 'professional project', or professionalisation, which comprises the following steps: 1) an occupational group competing for social rewards; 2) the 'project' comprising two main objectives to gain market monopoly and status to meet the social closure strategy; 3) to gain and maintain the sub-goals of jurisdiction, producing the producers (appropriate education, training and socialisation), monopolisation of professional knowledge, and respectability; 4) relations with other relevant 'actors' e.g. the state, other occupations, education institutions and the public; and, 5) consideration of the social, political and cultural context.

Whilst the above definitions differ in their content, the overarching concept of professionalisation is that of a process towards achieving the end status of a profession i.e. occupational closure. Evetts (2012) claims that whilst the notion of professionalisation in the studies of professionalism has declined

since the 1970s it is seen to be of value in the examination of emerging professions, particularly in relation to standards of education, training and accreditation for practice.

The preceding sections have described what may be considered as traditional schools of thought within the sociology of the professions; the next section questions the relevance of these within a modern NHS and considers an alternative model of professionalism for healthcare staff.

2.6.5 Contemporary Professionalism

The traditional professionalism ideology is seen by many as outdated with patients having much higher expectations (Eraut 1994; Scottish Government 2012) and increased knowledge (Evetts 2012; Scottish Government 2012); healthcare professionals having less power and autonomy due to the control that the modern NHS has over them as a result of clinical governance systems such as evidence-based practice, Continuing Professional Development (CPD) and standardisation via guidelines and protocols (Coyler 2004; Southon and Braithwaite 2000; Taylor, Nettleton and Harding 2003); and, a blurring of traditional role boundaries (Dowling et al. 2000; Scottish Government 2012). These factors exist within a context of changes in modern healthcare including an aging population placing higher demands on the NHS which has limited resources, and practitioners in the NHS facing more scrutiny now than they ever have before (Scottish Government 2012).

Are the diminishing powers of healthcare professionals, the demystification of knowledge and the educated patient 'deprofessionalising' healthcare practitioners? Does it matter if healthcare occupations are recognised as professions? Or is it professional attitudes and behaviours that are crucial? The public expect and are entitled to be treated by healthcare staff in a professional manner. As a result of the aforementioned notorious cases of Beverly Allit (Great Britain. Department of Health 1994), Bristol Children's Hospital (Great Britain. Department of Health 2001) and Harold Shipman (The Shipman Inquiry 2005), the White Paper 'Trust, Assurance and Safety – The regulation of Health Professionals in the 21st Century' (Great Britain. Department of Health 2007) brought about improvements in the regulation of healthcare workers to tackle the public's concerns.

More recently the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry' by Robert Francis QC (The Mid Staffordshire NHS Foundation Trust 2013) identified horrific instances of unprofessional attitudes and behaviours that are difficult to comprehend, so poor was the quality of care and so terrible the standards that were accepted by those who were supposed to be caring for patients in the guise of being healthcare professionals. The Mid Staffordshire report has rightly led to a renewed focus on professionalism and the need for caring, compassionate and knowledgeable healthcare workers who take accountability for their own practice and raise concerns about the behaviour, actions or health of any other healthcare professional or systems that may affect patient care or public safety. The Keogh (2013) review into the quality of care and treatment

provided by 14 hospital Trusts in England also emphasises the requirement for healthcare staff to act and behave in a professional and caring manner, placing patient safety above all else.

Nursing and the allied health professions have for some time been exploring professionalism in healthcare; in 2012 ‘Professionalism in nursing, midwifery and the allied health professions in Scotland: a report to the coordinating Council for the NMAHP Contribution to the Healthcare Quality Strategy for NHSScotland’ (Scottish Government 2012) was published. This report contains a number of recommendations, including a proposal for all healthcare workers to utilise a “single set of shared behaviours and values to focus the efforts of all staff” (p.13). The authors’ priority was to use a model that would help healthcare staff to understand professionalism and what was expected of them in terms of professional practice. The model selected was Stern’s (2006) principles of professionalism, the principles being excellence, accountability, humanism and altruism, with the report’s authors adding definitions and related concepts to put these principles into context.

In addition to Stern’s principles, the authors identify further characteristics necessary to facilitate professional practice that are related to the individual, including a preparedness to raise concerns and to undertake reflective practice. With regard to organisational input they highlight the need to embed professionalism in daily practice along with “strong leadership, committed organisational support, empowered staff, partnership working and a commitment to securing patient/service feedback to inform activity” (Scottish

Government 2012, p.18). They assert that professionalism is enabled by positive team cultures, positive role models and ongoing review of individual performance; furthermore, that potential employees should be assessed against professional characteristics and on commencing employment should clearly understand the expectation for professional practice (Scottish Government 2012).

2.7 Summary of the Theoretical, Practice and Policy Literature Review

In summary, sections 2.2 to 2.6 have presented a brief history of pharmacy, the modernisation of hospital pharmacy and the development of the pharmacy technician role as a result of various drivers, most notably 'The Right Medicine' (Scottish Executive 2002) and the recently published 'Prescription for Excellence' (Scottish Government 2013a). NHS reforms, changes to the regulation of healthcare staff and legislative changes which enabled the regulation of pharmacy technicians were described. The notion of professional recognition as a result of regulation was then examined in the context of the sociology of the professions. Here, the main theories were explored: trait theory, power theory and professionalisation, followed by a consideration of contemporary professionalism in the NHS. Trait theory involves professions displaying particular traits or characteristics; power theory considers professions as self-interested and is concerned with the strategies and techniques used to gain, maintain and develop occupational closure; professionalisation is a dynamic process, built upon trait theory or power theory, towards achieving the end status of recognition as a profession.

However, in contemporary professionalism these theories may be regarded as outdated given the major changes in the NHS over the last 30 years or so. These changes include: clinical governance reducing power and autonomy of the healthcare professions; the demystifying of medical knowledge; blurring of healthcare roles; higher patient expectations; and an aging population with increasing demands on a cash-strapped health service. The Keogh (2013) and Mid-Staffordshire (The Mid Staffordshire NHS Foundation Trust 2013) reports renewed the focus on the need for professional attitudes and behaviours. In line with this, Nursing and Allied Health Professions (Scottish Government 2012) have proposed that Stern's principles of professionalism, namely excellence, accountability, humanism and altruism, are used by *all* healthcare workers as a focus for professionalism.

This concludes the overview of the theoretical, practice and policy literature. The next section reports on the relevant empirical literature related to pharmacy technicians and professionalism.

2.8 A Critical Review of the Empirical Literature

Whilst there is a plethora of literature on the medical profession and regarding professionalism, there is little published literature on pharmacists and professionalism and even less related to pharmacy technicians, as established by other researchers (Elvey et al. 2011; Elvey, Hassell and Hall 2013; Schafheutle et al. 2012). Only three studies which have some relevance to the present study were found. First a study by Middleton (2007),

‘What do technicians think about registration and professionalism?’ was carried out four years before mandatory registration and therefore in a different context. Second, Schafheutle et al. (2012) carried out a study into ‘Pharmacy technicians’ views of learning and practice implementation’. Lastly, a report for Pharmacy Research UK by Bradley et al. (2013), which although entitled ‘Supervision in community pharmacy’ included hospital pharmacists and pharmacy technicians in its study population. A critical review of these three pieces of empirical research follows.

2.8.1 Pharmacy Technician Views on Registration and Professionalism

The Middleton study (2007), carried out in London hospital pharmacies in spring 2006, invited pharmacy technicians to express their views on registration and professionalism. Nine pharmacy technicians were interviewed, three of whom were voluntary registered pharmacy technicians, all were female and in senior roles with between two and twenty years post-qualification experience. Regarding professionalism, all participants identified standards of conduct as important and one expressed the view that there are different perceptions of accountability amongst pharmacy technicians. Most thought that professional recognition would be a consequence of registration and that registration might raise the profile of pharmacy technicians. Challenges related to professional behaviours included pharmacy technicians’ attitudes e.g. “just want to do their dispensing and go home” (p.101). Pharmacists’ attitudes to role development were also considered a challenge in terms of resistance to pharmacy technicians taking on roles traditionally

undertaken by pharmacists. Time to undertake CPD was also identified as an issue.

The author concludes that the pharmacy technicians who participated in the study considered themselves professional but that there was a need for a separate professional identity to differentiate them from pharmacists. Concerning education and training, this research found that pharmacy technicians' qualifications provide the knowledge and skills relevant at that time, but that vocational training does not prepare students for professional roles as it utilises replication and application modes of knowledge use. Further, that there are gaps in education and training particularly around making professional judgments, the Code of Ethics and undertaking CPD.

There was very little information provided on the research design, recruitment strategy, sampling, data collection, data analysis, ethical considerations or researcher reflexivity. The researcher's relationship to the participants is unknown so any influence over respondents cannot be established. Furthermore participants were invited to respond resulting in sampling bias (Bowling 1997). Whilst this study was carried out prior to mandatory registration, within the limitations outlined above it provides an insight into pharmacy technicians' need for a separate professional identity and it identified gaps in pharmacy technicians' initial education and training.

2.8.2 Pharmacy Technicians' View of Learning and Practice Implementation

Schafheutle et al. (2012), in their research into pharmacy technicians' views of learning and practice implementation, were interested in pharmacy technicians' understanding of CPD and learning, and how their learning is implemented in practice. The GPhC requires its registrants to make nine CPD entries each year.

In July 2008 a survey was sent to 216 pharmacy technicians who had attended a workshop on influencing skills, receiving a 68% response rate. No information is provided on the basis of the survey design. Potential weaknesses related to surveys include that the use of closed-questions in questionnaires can limit availability of appropriate choices for respondents if not worded sufficiently well (Bowling 1997) and ensuring validity of the questionnaire measures can be problematic (Boynton and Greenhalgh 2004). Analysis in this study utilised Statistical Package for the Social Sciences (SPSS) and the framework method to analyse qualitative data. The results include that 84.2% of respondents had put at least one aspect of learning into practice and of these respondents 73% had used their learning to create a CPD record. In accordance with Middleton (2007) the 43 respondents who had not created a CPD record mainly identified time as the barrier, with two of these responding that they did not get time at work to record their CPD. As with the Middleton (2007) study, this research was carried out prior to mandatory registration for pharmacy technicians and there is no indication as

to how many of the respondents were on the voluntary register. Further, the authors acknowledge that the study population may not be representative given that they were motivated to attend an educational workshop. However, the findings give an insight into the application of learning and the reasons that some pharmacy technicians gave for not using this learning to create a CPD record.

2.8.3 Supervision in Community Pharmacy

The third study, carried out in England by Bradley et al. (2013), aimed to "investigate current arrangements for supervision, role delegation and skill mix in community pharmacy and to seek stakeholders' perceived risk levels associated with different types of pharmacy activities and services, and views on potential changes to supervision requirements" (p.11). Furthermore, the intention was to use the results to inform government consultation on supervision. The results of this study have also been presented at an 'Optimising Pharmacy Skill Mix' workshop (Great Britain. Department of Health 2014) and at an event in my local Health Board organised by the Royal Pharmaceutical Society.

Whilst the focus of this study was community pharmacy in England (and not the UK due to the differences over pharmacy contractual arrangements in the home countries), it included hospital pharmacy technicians and pharmacists. The authors state that this was in recognition of the more advanced roles and progress with skill mix in hospital pharmacy and the learning they hoped to

glean from this in relation to advancing roles and skill mix in community pharmacy.

A mixed methodology was used: the qualitative stage involved the use of the nominal group technique (NGT) with hospital and community pharmacists and 'pharmacy support staff', the purpose being to use the NGT to develop a semi-structured interview schedule for use with superintendent pharmacists, and to inform development of a survey, the latter forming the basis of the quantitative analysis. The mixed methodologies used seem appropriate as using qualitative research to inform survey design can be beneficial (Pope and Mays 2006).

During the nominal groups, the superintendent interviews and in the survey, participants were asked questions related to activities that can be carried out by 'pharmacy support staff' when a pharmacist is not physically present. The survey also asked if support staff carried out these activities without the physical presence of a pharmacist, what the risks to patient safety would be. The survey was sent to registered pharmacists and pharmacy technicians in England, using random sampling carried out by the GPhC. A 50% response rate was achieved comprising 100 hospital pharmacists (18% of overall pharmacist responses) and 286 hospital pharmacy technicians (37% of overall pharmacy technician responses).

The researchers include the following staff in their definition of support staff: medicines counter assistant; pharmacy assistants; pharmacy technicians; and

accredited accuracy checking technicians, and provide an overview of their roles and qualifications. They note that medicines counter assistants undertake a GPhC accredited medicines counter assistant course; dispensing assistants are required to have a Level 2 National Vocational Qualification (NVQ); and pharmacy technicians require a Level 3 NVQ. What the researchers do not explain is that the medicines counter assistant course is a three-six month competency-based course; the dispensing assistants course comprises the Level 2 NVQ (or equivalent qualification) units relevant to the role (so dispensing assistants may not have the full qualification) and it is also a competency based qualification normally taking between 6 and 12 months to complete (General Pharmaceutical Council [no date] a). They also fail to note that as well as the full NVQ 3 qualification, pharmacy technicians must have a knowledge based qualification at national diploma (England) or national certificate (Scotland) level, with their training taking two years to complete (General Pharmaceutical Council [no date] b). Accredited accuracy checking pharmacy technicians require to have successfully completed a further course of study in order to carry out the final accuracy check on dispensed medicines. Thus registered pharmacy technicians, accredited accuracy checking pharmacy technicians, dispensing assistants and medicines counter assistants, with their vastly different training, qualifications and accountabilities, are all amalgamated under the one category of 'pharmacy support staff'. Whilst the authors recognise this as a limitation, they counter it with "... the competencies and knowledge of pharmacy technicians being ***possibly*** more advanced than those of pharmacy/dispensing assistants" (p.31) (my emphasis). This is akin to asking

doctors what activities they would delegate to registered pharmacy professionals, which would include pharmacists and pharmacy technicians. It is apparent that participants would answer questions based on the 'lowest common denominator' and consider medicines counter assistants' capabilities when answering these questions. However with this significant limitation in mind, the results are still of interest to the present study.

The data analysis methods for the quantitative aspects of this study were comprehensive and explained for the nominal group and survey findings. However there is no information on how the qualitative data were analysed, what excerpts were used or not and why, so there is a lack of transparency over these methods of analysis. Overall the main findings relevant to my study can be categorised into four main themes: accountability and responsibility; delegation; capability; and, control.

Accountability and responsibility

The authors claim that there was agreement from the four professional groups (hospital and community pharmacists and pharmacy technicians) that registration means that pharmacy technicians should be "more accountable for the tasks they perform" (p.52). They also report that pharmacy technicians "were less clear about whether they would be willing to take ultimate responsibility for their own actions". It is questionable if pharmacy technicians actually have a choice in this matter. The GPhC (2012a) 'Standards of conduct, ethics and performance' states "You are professionally accountable for your practice. This means that you are responsible for what you do or do

not do, no matter what advice or direction your manager or another professional gives you" (p.7). However the supervision debate in community pharmacy and the role of the 'Responsible pharmacist' as a result of the Health Act (2006) appear to complicate accountabilities in registered pharmacies. Both hospital and community pharmacists identify that there needs to be clarification over who is accountable when pharmacy support staff undertake 'extended' roles.

Delegation

Another theme that is relevant is the decision-making around 'delegating' activities, with pharmacists claiming that it depends on how well you know and trust your team. On the other hand, 'support staff' in hospital and community pharmacy reported an awareness of their own competency and limitations. While it is correct that as a professional one is accountable to delegate to staff competent to carry out the role (General Pharmaceutical Council 2012a), it could be argued that there should also be role definition based on the qualifications and experience of the staff and not down to the discretion of individual pharmacists on a day-to-day basis. Closely linked to delegation are perceptions on capability.

Capability

Although this is not noted by the authors, it is apparent that there is confusion over the grand-parenting arrangements for pharmacy technicians' registration with one community pharmacist claiming that this allows registered pharmacy technicians to "have no formal qualifications" (p.63), which is incorrect, but

one on which he/she based his/her responses. The need for Standard Operating Procedures was also identified which indicates that pharmacy technicians do not require to use professional judgement and instead all activities require to be clearly proceduralised. However there were also accounts of pharmacists reporting that pharmacy technicians' skills were undervalued and their capability not recognised.

Control

Lastly of interest is the notion of community pharmacists being unwilling to "relinquish control" (p.68). This opposition to 'support staff' carrying out roles traditionally undertaken by pharmacists was also reported at a joint workshop organised by the RPS and the APTUK (Great Britain. Department of Health 2014) and is a fundamental factor that will require to be addressed to reach optimum skill mix.

Interestingly the six superintendent pharmacists interviewed were pro-change, recognising the need for alterations to supervision and to make the most of the pharmacy technician role in particular. However they also highlighted the need to clarify accountabilities of the pharmacy team. It is perhaps not surprising that leaders have a more visionary outlook than front line staff who are possibly more likely to be concerned with how changes will affect them and potentially resistant to take on new roles.

The findings from this study highlight the differences in current roles and future aspirations for pharmacy technicians in hospital compared to

community pharmacy, and this is important considering that the ‘Standards for the initial education and training of pharmacy technicians’ set by the GPhC are for pharmacy technicians regardless of where they work (General Pharmaceutical Council 2010a), and that these standards are in the process of being reviewed (Anon. 2013). There is clearly confusion over accountability amongst pharmacists and pharmacy technicians in particular as registered pharmacy practitioners, and clarifying this would aid the further advancement of pharmacy technician roles (Dowling et al. 2000).

Whilst some of the findings of this research are relevant to the present study, concerns are related to the amalgamation of pharmacy technicians with support staff considering that their education, training and professional status should set them apart, and also the use of front-line staff to identify what activities pharmacy ‘support staff’ can undertake as there may be a lack of vision and understanding of qualifications, along with a resistance to change from some respondents. This is exemplified by the superintendent pharmacists who, in leadership positions, identified the need for advanced roles and recognition of pharmacy technicians as accountable professionals. Finally, it is a concern that the results of this study are being presented and used to inform policy with no recognition that the method is flawed in relation to the overarching use of the term ‘pharmacy support staff’ in determining role expansion.

2.9 Summary of the Empirical Literature Critical Review

The empirical literature review highlighted the lack of research into pharmacy technicians' regulation and professionalism. Three partially relevant studies, whilst acknowledging their limitations, identified some findings that were considered pertinent to the present study. Middleton (2007) and Schafheutle et al. (2012) established that the time taken to do CPD was a barrier. Middleton (2007) and Bradley et al. (2013) concluded that pharmacists were reluctant to have pharmacy technicians taking on roles previously undertaken by pharmacists. Middleton (2007) found that pharmacy technicians' attitudes towards their role would challenge professional recognition, and further, that pharmacy technicians' education and training did not adequately prepare them for professional practice. Bradley et al. (2013) noted the requirement to clarify accountabilities amongst the pharmacy team particularly regarding extended roles. Bradley et al. (2013) also highlighted the difference between aspirations for pharmacy technician role development in community pharmacy and hospital pharmacy, which is an issue to be addressed in considering that the GPhC 'Standards for the initial education and training of pharmacy technicians' (General Pharmaceutical Council 2010a) are the same regardless of where pharmacy technicians are employed.

2.10 Conclusion and Justification for the Present Study

The pharmacy technician role in hospital has transformed over the last two decades, with pharmacy technicians taking on roles previously undertaken by

pharmacists, including more patient-facing roles, leading to greater responsibility. In the interests of patient safety, since 2011, pharmacy technicians must be registered with the GPhC to practise. Registration brings with it professional recognition, and whilst this may be seen by some as important, I believe that the critical aspect of being a member of a profession in the 21st century is professionalism: the requirement for a knowledgeable practitioner with the appropriate professional attitudes and behaviours enabled by a suitable infrastructure to provide patient-centred care. This focus on professionalism over the concept of profession or professionalisation is one espoused by Evetts (2012) and Lorentzon (1992), and is apt in the light of the renewed focus on the need for professional practice highlighted as a result of the Mid Staffordshire Report (The Mid Staffordshire NHS Foundation Trust 2013) and the Keogh (2013) review.

As has been acknowledged by other commentators (Elvey et al. 2011; Elvey, Hassell and Hall 2013; Schafheutle et al. 2012), there is a dearth of published research about pharmacy technicians and professionalism. Of the three partially relevant studies identified in the empirical literature review, none offers a holistic exploration of pharmacy technicians' regulation and professionalism post mandatory registration, which this study aims to do using the sociology of the professions as the theoretical framework.

The sociology of the professions section in this chapter described competing approaches amongst the theories and even within these approaches there are ontological and epistemological differences. Given that the focus of this study

is the concept of professionalism in modern healthcare, the approach taken draws upon the Nursing, Midwifery and Allied Health Professionals report on professionalism (Scottish Government 2012) using Stern's (2006) principles of accountability, altruism, humanism and excellence as a basis for the characteristics of professionalism against which the pharmacy technician profession will be compared. In addition, there will be consideration of the structural characteristic of a specialised knowledge base in relation to preparing pharmacy technicians for professional practice. Whilst the focus of this study is professionalism, rather than the professions or professionalisation, in effect this approach draws on aspects of the three main theories of the professions: trait theory, the power approach and professionalisation, as illustrated in Figure 2-2.

Figure 2-2 Theoretical approach for the present study

PROFESSIONALISATION	Stern's Principles	Trait Theory	Power Approach
	Accountability		
		Structural Aspect: **Specialised Body of Knowledge**	
	Altruism		
	Humanism		
	Excellence		

3 METHODOLOGY

3.1 Introduction

This chapter commences with a description of the social constructionist approach taken in the present exploratory study before outlining discourse analysis and four of its variants, including the type of discourse analysis used for this research. There follows a justification for this approach, an overview of its perceived limitations and a brief counter-argument against these. Thereafter the methods used to develop the research questions from the initial aims of this research are explained, followed by details about the research participants in terms of identification of, and access to, research sites, and the sampling strategy employed to select participants. The method for data collection is explained including the data collection challenges faced. The data analysis section then provides details of the procedures developed and used to conduct discourse analysis in this study. Ethical considerations are then described followed by a section on reflexivity, where I disclose my potential subjectivities and how I managed these. Finally, issues of warrantability are introduced along with the steps taken to help support rigour in this study.

3.2 Research Approach

A literature review established that little is known about the regulation and professionalisation of pharmacy technicians and therefore a qualitative

approach is appropriate to explore this topic (Morse and Field 1996). The principal methodology for this study is discourse analysis, which is not a single method but a whole perspective within the social constructionist approach on the study of language in use (Gill 1996; Potter 1996a, 1996b; Taylor 2001a).

Prior to defining social constructionism it is appropriate to point out that the act of doing so is itself anti-constructionist, in that providing a definition is a realist approach and thus one that considers constructionism as a stable, ahistorical, acultural phenomenon that can simply be described (Potter 1996a). Nevertheless, it is necessary to set this issue aside in order to explain the philosophical assumptions underpinning this study.

There is no single definition of social constructionism; rather it is considered a theoretical framework spanning a number of disciplines within which there are shared assumptions (Burr 2003; Harper 2006). Gergen (1985) identified four key assumptions in most social constructionist approaches; these epistemological (the nature of knowledge) and ontological (the nature of reality) assumptions are:

1. A critical position regarding 'taken-for-granted' knowledge, that is, a rejection of the positivist assumption that there is an objective truth 'out there' comprising value-free facts;
2. Knowledge is culturally and historically specific. In other words, the ways we understand the world are situated and therefore dependent on the current social and cultural interpretations;

3. Knowledge is sustained by social processes. Thus knowledge is not considered to rely on empiricism but is believed to be subjective and constructed by people through their interactions;
4. Knowledge of the world constructs social action. Therefore culturally and historically specific knowledge produces different constructions which invite different social actions.

Within the social constructionist approach language is considered a central feature in our ways of understanding the world (Burr 2003; Potter 1996a). Burr (2003, p.8) explains that:

> *Concepts and categories are acquired by each person as they develop the use of language and are thus reproduced every day by everyone who shares a culture and a language. This means that the way a person thinks, the very categories and concepts that provide a framework of meaning for them, are provided by the language that they use. Language therefore is a necessary pre-condition for thought as we know it.*

The term 'discourse' is one used by social constructionists in the study of language. Discourse can be defined as "... a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a version of events" (Burr 2003, p.64). Discourse analysis has its foundations in Chomsky's linguistic work on grammatical features of discourse, John Austin's speech act theory and ethnomethodology (Potter and Wetherell 1987), with discourse analysis developing from these to cover a range of approaches across a variety of disciplines (e.g. philosophy, psychology, sociology, anthropology, linguistics) in the study of language (Gill 1996; Potter and Wetherell 1987). Within these different perspectives three

fundamental assumptions about language are shared around function, construction and variation. Language *function* is concerned with people doing things with their language e.g. justifying, persuading, blaming, and to do this people *construct* language in a *variety* of ways depending on its function, although this is not necessarily intentional (Potter and Wetherell 1987). Thus discourse analysts are anti-essentialist, rejecting the notion that language is used only to represent inner mental processes and instead consider talk as an activity that is occasioned and the meaning of which can change radically in different contexts (Gill 1996). Consequently, discourse analysis is an alternative to other qualitative research approaches which consider the researcher representing what participants 'think'.

Discourse analysis utilises a range of types of talk and texts with the choice depending on the discourse analysis approach (Wood and Kroger 2000). The different varieties of discourse analysis include conversation analysis, discursive psychology, critical discourse analysis and broad discourse analysis, and these approaches are briefly outlined next.

Harvey Sacks is acknowledged as the founder of conversation analysis which is concerned with naturally occurring talk (Wooffitt 2005). Conversation analysis is not interested in the factual content of conversation but how people construct accounts and interactions (Burr 2003). Conversation analysis focuses on sequential analysis, that is "It is not interested in single utterances, but it is centrally concerned to explore how utterances are designed to tie with, or 'fit' to, prior utterances, and how an utterance has significant

implications for what kinds of utterances should come next" (Wooffitt 2001, p. 54). Thus conversation analysis is interested in the mechanics of how social action happens through conversation, looking at social order at the level it is produced. To enable analysis of talk-in-interaction, a key feature of conversation analysis is the detailed transcription system: naturally occurring talk is transcribed using the Jefferson system, which involves the use of symbols to represent not only what was said but also how it was said, the sequence of talk and other components such as pauses, over-laps in conversation, breaths, emphasis and laughter (Wooffitt 2005). The micro-level 'fine-grained' analysis seen in conversation analysis is often used in the study of discursive psychology, another variant of discourse analysis.

Discursive psychology originates in social psychology but moves away from the traditional cognitivist approach to psychology, instead being concerned with how people construct and present versions of themselves and events as factual by analysing interaction at a micro level (Burr 2003). Thus discursive psychologists study ways that cognitive processes are used to do things in language and to sustain interaction (Edwards and Potter 1992; Wooffitt 2005); language is seen as a topic rather than a resource. Discursive psychology is interested in how language is used to construct facts and deal with issues of accountability, stake and interest (Wood and Kroger 2000). While traditional psychological research methods involved experimental design, discursive psychology relies on empirical methods, using transcripts of natural conversations or planned interviews, and television or newspaper reports (Burr 2003).

A further variety of discourse analysis is critical discourse analysis, which emerged from linguistics and sociolinguistics, with key researchers in this field being Fairclough, van Djik and Wodak (Wooffitt 2005). Critical discourse analysis is concerned with "…the role of discourse in the production and reproduction of power relations within social structures" (Wooffitt 2005, p.138). Thus critical discourse analysts are interested in social issues (Fairclough 2010; Wodak 2013): they start with a socio-political stance regarding power relations and set out to establish how discourse sustains the power of dominant groups and disadvantages minority groups (Fairclough 2010; Wooffitt 2005). To do this, critical discourse analysis utilises a variety of texts which may be written, transcribed talk, television programmes or visual images (Fairclough 2010). It takes a linguistic approach to analysis to explore how word choice, grammar etc. are used in power relations, both in terms of resisting and maintaining dominance, and is also concerned with the use of repertoires and ideology (Fairclough 2010; Wooffitt 2005).

Lastly, the 'broad brush' variant of discourse analysis is the type of discourse analysis first proposed by Potter and Wetherell in their seminal work 'Discourse and Social Psychology' (1987) and is concerned with looking at broad accounts, discourse practices (what people do with their talk i.e. the action orientation of discourse) and discursive resources that people draw on in their talk e.g. 'reported speech' or 'active voicing', where a speaker seemingly quotes or paraphrases other speakers, which works to make an account vivid and more factual (Potter 1996b).

Discourse analysis is an appropriate methodology for this study as the aim is to illuminate the ways in which pharmacy technicians and pharmacists construct professionalism by analysing what is present and absent in their discourse and relating this to the theories of the professions. The exploratory nature of this study, utilising interviews with pharmacy technicians and pharmacists carrying out different roles, is suited to a broad discourse analysis approach as it allows an exploration of the identified professionalism themes and getting 'underneath' the reported views of participants. The broad discourse analysis approach is taken as it is appropriate to the research questions in terms of a broad interest in talk at a meso-level, rather than the fine-grained analysis associated with conversation analysis and discursive psychology, and the prior socio-political stance that is fundamental to critical discourse analysis (Harper 1999; Wood and Kroger 2000). Further explanation of the discourse analytical procedures undertaken for this study is provided in section 3.6 'Methods for Data Analysis'.

Other qualitative research approaches were rejected as inappropriate for the research questions in the present study. For example, content analysis may have been a suitable approach had the aims of the research been to establish pharmacy technicians' opinions on professionalism. Content analysis would pull out broad themes based on categories and frequencies using statistical analysis with a view to finding out what the discourse may 'reveal' in terms of essences or cognitions. Content analysis therefore irons out variability. In contrast, discourse analysis does not utilise exclusive categories, since discourse can have various functions and meanings dependent on the

context, and thrives on variety. Discourse analysis focuses on the discourse itself; considering its function, structure and organisation, which enables "… sensitive, penetrating analysis" (Wood and Kroger 2000, p.33).

Alternative methods of qualitative research would not provide the depth of engagement or discussion appropriate for the research questions for this study; discourse analysis allows for an exploration of participants' takes on regulation and professionalism in a free-flowing way, not constrained by tick boxes or attitude scales.

Discourse analysis has been used to explore professionalism in other disciplines, for example Nixon and Power 's (2007) study on midwifery professionalisation; Shirley and Padgett's (2010) article on the discourse of medical professionalism; Pollard's (2011) research on midwives' professional identities and issues of power; and, Monrouxe, Rees and Hu's (2011) study on medical students explicit discourses of professionalism.

I have justified the discourse analytic approach taken within a social constructionist framework in this study and outlined the strengths of discourse analysis; however, it is appropriate to acknowledge the perceived limitations with this approach. It is recognised that discourse analysis is a difficult technique to master (Gill 1996; Harper 2006; Potter 1996a) and that there are many examples of poor discourse analysis (Antaki et al. [no date]), but one of the main criticisms about discourse analysis and the social constructionist approach is a perceived lack of generalisability and applicability of the findings

(Harper 2006; Potter 2012). This contested issue arises due to questioning how findings can be generalised and recommendations made when one assumes that there is no objective truth 'out there'.

Whilst there are a variety of perspectives on the nature of reality amongst social constructionists, Harper (2006) posits that social constructionists assume that there is no such thing as objective reality, however, this is not the same as denying that reality exists but "rather, that what we know as 'reality' is socially constructed and, indeed, that there are often different competing versions of reality which may be a source of dispute between speakers" (Harper 2006, p.49). Moreover, Sandberg (2005, p.46) claims that "it does not follow from the rejection of objective truth that we cannot produce valid and reliable knowledge about reality". Taylor (2001b) points out that a stance taken by many discourse analysts is 'subtle realism', as described by Hammersley (1992, cited in Taylor 2001b, p.325), whereby researchers "may accept that their findings are situated, partial and contingent but still suggest that they have implications for future practice and other contexts". Furthermore, Wood and Kroger (2000) claim that it is as acceptable to generalise from discourse analysis findings as it is from other forms of qualitative research. Nonetheless, one could question whether generalisation is a critical feature of discourse analytic research or a 'throwback' to positivist methodology; whilst generalisability may suit scientific criteria it takes us away from the variability of what people themselves exhibit as well as ignoring the cultural and historical specificity of knowledge. It could be argued that this

"craving for generality" (Wittgenstein 1974, p.17) is the problem, rather than a lack of generalisability being an issue in discourse analytic research.

The applicability of discourse analytic research is another disputed area (e.g. Potter 2012; Potter and Wetherell 1987; Taylor 2001b) with the main criticism being that this type of research is merely descriptive and not of any practical use. Potter and Wetherell (1987, p.174) refer to this criticism in terms of "just looking at words – not real things". However, other commentators argue that discourse analysis findings are applicable, for example Willig (1999, p.154) claims that "discourse analysis can generate insights which can be incorporated into existing interventions in order to improve these". Harper (1999, 2003, 2006) also argues for the application of discourse analytic research particularly in terms of targeting different groups and reporting what may be of relevance to them. Harper (2006), Potter and Wetherell (1987), Willig (1999) and Bloor (1997 in Taylor 2001b, p.324) propose that it is important to take the findings from discourse analytic research back to practitioners in a form of action research. This approach can be used to empower practitioners and influence practice, policy and education.

In summary, the research approach taken involves a discourse analysis methodology to analyse language at a 'broad brush' level in terms of its function, construction and variation in the ways pharmacy practitioners talk about regulation and professionalism. Discourse analysis is a perspective within the social constructionist paradigm in which knowledge is considered to be situated historically and culturally, and constructed through interaction

rather than being the possession of the individual. From this perspective an analytical move into the space that is shared between persons where different constructions of knowledge lead to different social actions, means that multiple perspectives are permissible. This approach has its critics regarding a perceived lack of objectivity, generalisability and applicability of research findings. However, within this thesis such criticisms are rejected in favour of adopting a 'subtle realist' stance whereby the research findings are accepted as being situated, contingent and partial, but nonetheless considered with respect to the criteria of credibility and applicability (Hammersley 1992, cited in Taylor 2001b).

Notwithstanding the points made above, in order for the findings from research undertaken within the social constructionist paradigm and the discourse analysis methodology to be considered applicable, there is a fundamental requirement for warrantability (e.g. Potter 1996a; Sandberg 2005; Wood and Kroger 2000). Section 3.8 within this chapter provides information on the steps taken to warrant the claims made in forthcoming chapters.

3.3 Development of Research Questions

This section describes the approaches taken to further develop the research questions from the initial aims of the research, commencing with situational analysis.

Situational analysis is a set of methods developed by Adele Clarke (2005) that utilises cartographic approaches in the form of three types of map: the situational map; the social world/arenas map; and, the positional map. Situational analysis was considered appropriate for this study to help broaden my perspective and provoke new areas to consider within the research field by talking to pharmacy technicians and pharmacists about their lived experiences. Contact was made with a Health Board in Scotland where the pharmacy Head of Service agreed I could carry out situational analysis.

Meetings with pharmacy technicians, pharmacists and the Head of Service were arranged on a voluntary basis and a topic guide used to guide the discussion (appendix 1). Participants were informed about the purpose of the meeting and the procedures being used to help preserve their anonymity. Given the informal nature of these meetings written consent was not required but all participants were asked if they were in agreement to proceed. Brief notes were made and used to prepare the situational map. Here, the first step was to produce what Clarke (2005) calls a “messy” or “working” map based on the interview data as well as the researcher’s assumptions. This ‘messy’ map identified who and what were in the situation, including human and non-human actants, symbols and discourses, and was deliberately unordered to avoid premature closure (appendix 2). The data was then developed into an ordered map which organised the data (appendix 3).

The next step was to carry out relational analyses, whereby each component was considered in relation to all other components, and this highlighted

relations that had not previously been considered. Further information is provided in appendix 4 but the key relations identified were: professionalism; working relationships; accountability; education and training; and, practice development. Whilst Clarke (2005) describes three types of map, for the purpose of this study the situational map was focused upon as that provided sufficient information to enlighten development of the research questions and the interview guides. However the research questions continued to be modified and reworded as the research progressed considering theoretical underpinnings and aspects illuminated by the data (Gill 1996; Harper 2006; Taylor 2001a).

The research questions for this study are:

I. How do pharmacy practitioners present pharmacy technicians in relation to contemporary professionalism characteristics?

II. How do pharmacy practitioners account for roles and future practice development in light of pharmacy technician regulation?

3.4 Research Participants

3.4.1 Research Sites and Access

Whilst pharmacy technicians work mostly in community pharmacy and hospital pharmacy (there are also roles outwith these areas including within HM Prison services, General Practitioner practices, the Armed Forces and

industry e.g. manufacturing units) the focus of this study is hospital pharmacy technicians. This is primarily due to the different organisational arrangements in community pharmacy: these are business-oriented private contractors and the roles and responsibilities of pharmacy technicians are quite different to those working in hospital. Moreover, my experience, responsibilities and influence lie within hospital pharmacy services, both at a local and national level.

Two Health Boards were identified as potential research sites by referring to the Audit Scotland report 'Managing the use of medicines in hospital: a follow up report' (Audit Scotland 2009). This report identified the tasks that pharmacy technicians were carrying out at different levels of seniority by Health Board. Utilising my knowledge of pharmacy and pharmacy technicians' roles enabled the identification of Health Boards where pharmacy technicians appeared to be working in more traditional roles and those where pharmacy technicians were working in more 'advanced' roles on wards. Pharmacy technicians who work in ward roles deal directly with patients and work more with the multidisciplinary team compared to those who are pharmacy department-based. The purpose of selecting sites with differing roles was not to obtain a representative sample but instead to obtain versions from participants who, whilst similar in that they are all pharmacy professionals registered with the GPhC, have different roles and experiences and therefore potentially may provide different accounts (Wood and Kroger 2000).

A pharmacy education and training specialist colleague was asked to analyse the same Audit Scotland data and identify which Health Boards she considered had pharmacy technicians working at traditional and more advanced ward-based levels, without knowledge of how I had reached a decision and what that decision was. The same two Health Boards were identified thus providing a degree of inter-rater reliability. The Health Boards were anonymised in the original Audit Scotland report however this information was provided on request which allowed identification of the selected Health Boards. Through support from the local Director of Pharmacy, and after providing further information about the research protocol, the Directors of Pharmacy for the two selected Health Boards agreed to allow their staff to participate in this study.

3.4.2 Sampling

Potter and Wetherell (1987, p.161) argue that in discourse analysis "the success of a study is *not* in the least dependent on sample size" and that the "crucial determinant of sample size, however, must be, here as elsewhere, the specific research question". Moreover, discourse analysis is a labour-intensive approach in terms of the detailed transcription required, coding and analysis and therefore too much data threatens the quality of the detailed analysis (Potter and Wetherell 1987). Harper (2006) and Wood and Kroger (2000) purport that a theoretical sample is appropriate in discourse analysis i.e. selecting different categories of participant who may construct different accounts using different resources due to their social position.

For the present study a theoretical sample was selected from within the two participating Health Boards. One pharmacy technician from Agenda for Change Bands 4 to 7 were randomly selected (there were no Band 8 pharmacy technicians in either of the Health Boards). The entry level for pharmacy technicians is Band 4, usually in a rotational post; Band 5 is normally a senior pharmacy technician and may be rotational; section managers are normally Band 6; and, those in a more senior management position covering more than one section are a Band 7. A junior pharmacist (Band 6 or 7) and a senior pharmacist (Band 8a or 8b) were also randomly selected. All were contacted by email and a follow-up email sent when there was no response. When those selected did not reply or chose not to participate, a second random selection was done. In addition the Directors of Pharmacy from the same two Health Boards were invited to participate. One Director of Pharmacy did not respond and therefore a convenience sample (Flick 2014) was used to invite a Director of Pharmacy from another Health Board to participate.

3.5 Method for Data Collection

Interviews are extensively used to gather data for discourse analysis and can be particularly useful in questioning a sample of participants on the same topics (Potter and Wetherell 1987). Taylor (2001a) recommends that the interviewer should understand the language and references used by participants, and therefore as an 'insider' I was in a position to do this effectively. Moreover, participants were aware that as they were being

interviewed by an informed interviewer they could converse in a way that would perhaps not be possible with an 'outsider'.

An interview guide of mainly open questions with follow-up probes was produced based on my own knowledge, the situational analysis and the literature review. A guide was prepared for the three different populations, that is, pharmacy technicians, pharmacists and Directors of Pharmacy (appendices 5-7). Whilst the three guides mainly covered the same topics there were modifications, for example pharmacy technicians' questions were related mainly to themselves whilst pharmacists were asked questions about pharmacy technicians. The guide was used as a prompt only in an attempt to cover the main topics; however participants were encouraged to speak freely (Wood and Kroger 2000). In accordance with good practice (Bell 2005; Silverman 2010), pilot interviews were carried out to test the interview guide with two pharmacy technicians and a Director of Pharmacy. Whilst the feedback from the test participants was positive with no changes suggested, some alterations were made to improve the flow of questions. Carrying out the pilot interviews had the added benefit of enabling me to gain experience and become more comfortable and familiar with the questions and prompts.

Interview participants were provided with an information leaflet (appendices 8-10) prior to the interviews and signed a consent form (appendix 11) to participate in the research. Ten interviews with pharmacists and pharmacy technicians were carried out in October 2011; participant details are provided in Table 3-1 below:

Table 3-1 Interview participants

Band/Role	Health Board 1	Health Board 2
Band 4 Pharmacy Technician	x	✓
Band 5 Pharmacy Technician	✓	✓
Band 6 Pharmacy Technician	✓	✓ (Withdrew after interview transcribed)
Band 7 Pharmacy Technician	✓	✓
Band 6/7 Pharmacist	✓	x
Band 8a/8b Pharmacist	✓	✓

Once the pharmacy technician and pharmacist interviews and been transcribed and some preliminary analysis commenced, interviews with two Directors of Pharmacy were arranged and carried out in May 2013.

The interviews were digitally recorded with the duration of the interviews ranging from 11 minutes to two hours and a total of 610 minutes of interview data transcribed. All participants were emailed a copy of the transcript and asked to respond if they wished any of the content of the transcript to be removed, particularly due to any concerns regarding anonymity. Four participants replied with comments they thought would be helpful, seven did not reply and one asked to be withdrawn from the study regarding concerns over anonymity and therefore was excluded from the analysis. Thus a total of eleven interviews were included in the analysis for this study: six pharmacy

technicians; three pharmacists; and two Directors of Pharmacy. The interview transcripts are provided in appendices 12-22.

The data collection challenges faced were: gaining access to participants in one Health Board in particular; lack of response to emails from some potential participants; an intermittent recording problem that only became apparent after testing and using the equipment; and, the amount of data generated that required to be transcribed and then analysed.

3.6 Methods for Data Analysis

Discourse analysis is considered a scholarly exercise as there is no 'recipe book' to follow (Gill 1996). It is therefore a reasonably complex methodology for the novice researcher to undertake Gill (1996). Potter (1996a, p.140) considers discourse analysis a "craft skill" but that "there is no substitute for learning by doing".

To develop my discourse analytical skills I undertook a module on conversation and discourse analysis. I also read literature by renowned commentators on the topic (e.g. Harper 1999; Potter 1996a, 1996b; Potter and Wetherell 1987; Wetherell, Taylor and Yates 2001; Willig 2014; Wood and Kroger 2000) and research articles where a discourse analysis approach was taken, as recommended by Antaki et al. ([no date]). Further, I discussed aspects of my analysis with my academic supervisor to aid development of my interpretative skills in this area.

As there is no ‘recipe’ for carrying out discourse analysis (Gill 1996), I developed my own set of procedures for this study as illustrated in Table 3-2.

Table 3-2 Discourse analysis procedures for this study

1	Verbatim transcription of interviews from digital recording. Broad level analysis therefore transcription also at a broad level.
2	Familiarise self with transcripts by reading several times.
3	Identification of discourse to focus upon within each transcript.
4	Re-reading and analysis of individual transcripts looking at discourse practices and discursive resources used. Underline discourse referred to in the comments column for clarity and to support validation. Be aware that patterns may emerge in terms of consistency or variability in the data.
5	The analysis will be sensitive to context, understanding that the interviews are not naturally occurring.

The level of detail contained within transcripts depends on the research focus (Potter and Wetherell 1987; Taylor 2001a) therefore the broad discourse analysis approach taken in this research requires minimal detail recorded on the transcripts.

Interviews were transcribed verbatim and the following notations used:

( ) = unclear discourse on the recording and therefore unknown word(s);

(word?) = word(s) within parentheses are a best guess when discourse unclear.

Names, locations and discourse, which if exposed may affect anonymity, were redacted.

Whilst transcribing the interviews was very time-consuming it was a highly beneficial process as it allowed me to become familiar with the data (Morse and Field 1996). After transcription and becoming familiar with the transcripts the next step was to categorise the data. Potter and Wetherell (1987, p.167) explain that:

> *The goal is not to find results but to squeeze an unwieldy body of discourse into manageable chunks. It is an analytic preliminary preparing the way for a much more intensive study of the material culled through the selective coding process.*

The categories used are determined by the research questions (Gill 1996; Potter and Wetherell 1987). For the purposes of this study, the categories of Stern's (2006) principles of accountability, altruism, humanism and excellence were utilised with the addition of the structural aspect of a specialised body of knowledge. In order to consider how Stern's principles and related concepts could be identified in discourse, after the interviews an expert group in the form of members of the Scottish National Acute Pharmacy Services Group reviewed the contextualised definitions and concepts regarding excellence and accountability produced by the Nursing and Allied Health Professions (Scottish Government 2012), the outcome of which is illustrated in Table 3-3. The principles of humanism and altruism were considered self-explanatory although a definition from the Oxford Dictionaries (2014) is provided for the related concepts of humanism.

Table 3-3 Stern's principles, contextualised definitions and related concepts with evidence of application in discourse

Stern's Principle	Contextualised Definition	Related Concepts	Evidence of Application in Discourse
Excellence	Demonstrating practice that is distinctive, meritorious and of high quality	1. Commitment to competence 2. Commitment to exceeding standards (in education and practice) 3. Understanding of ethical principles and values 4. Knowledge of legal boundaries (and practice) 5. Communication skills	1. CPD including reflective practice 2. Advancing practice and advancing knowledge 3. Awareness of GPhC Standards of conduct, ethics and performance; examples of unprofessional behaviour 4. Did not explore 5. Did not explore
Accountability	Demonstrating an ethos of being answerable for all actions and omissions, whether to service users, peers, employers, standard-setting/regulatory bodies or oneself.	1. Professional: patient contract (including acknowledgement of unequal 'power' relationship) 2. Professional: social contract 3. Self-regulation (including standard setting, managing conflicts of interest, duty, acceptance of service provision, responsibility	1. Acknowledgement that patients perceive professionals as 'experts'; how deal with issues raised by patients; aim to ensure patients understand and adapt to meet patients needs 2. Takes responsibility; not expecting others more senior or pharmacists to take accountability for one's lapses/errors 3. Observes confidentiality and information governance regarding patients and colleagues; service and team focus not self-interest
Humanism	Demonstrating humanity in everyday practice.	1. Respect (and dignity) 2. Compassion 3. Empathy 4. Honour 5. Integrity	1. Due regard for feelings, wishes, or rights of others 2. Sympathetic pity and concern for the suffering or misfortunes of others 3. The ability to understand and share the feelings of another 4. The quality of knowing and doing what is morally right 5. The quality of being honest and having strong moral principles
Altruism	Demonstrating regard for service-users and colleagues and ensuring that self-interest does not influence actions or omissions.	1. Opposite of self-interest 2. Acting in the best interest of patients	1. Self-explanatory 2. Self-explanatory

(Adapted from Scottish Government 2012, p.14)

Discourse analysis requires a move away from a 'common-sense' reading to look at how accounts are constructed and the function of these accounts (Gill 1996). This is an iterative process back and forth between and across the transcripts and as particular discourse practices and discursive features become apparent. In addition, I was aware that patterns of variation or consistency within or across the transcripts could arise but due to the amount of data gathered this was not the focus of this study.

Transcripts were then searched for references to the contextualised definitions of Stern's (2006) principles of altruism, accountability, excellence and humanism, as well as a specialised body of knowledge. Where a direct question was asked e.g. regarding altruism, all participants responses were included in the analysis. The exception to this being when there was duplication within a participant's discourse that was not considered to add to the analysis; however this did not occur frequently. In addition where the category under analysis was mentioned at other points of the interview this was included if it was considered to add to the analysis, for example in relation to variation or consistency.

3.7 Ethical Considerations

The University of Abertay's School of Social and Health Sciences (SHS) Research Ethics Committee gave conditional approval (appendix 23) with the conditions being related to: clarification over confidentiality and anonymity; additions are made to the Participant Information Leaflet that the SHS

Research Ethics Committee has approved the study; that the interviews will be audio-recorded; data handling arrangements; contact details of the academic supervisor; clarification over how potential participants take part in the study; and, dissemination of findings. The conditions were accepted and acted upon.

The East of Scotland Research Ethics Service confirmed that this study did not require ethical review under the Governance Arrangements for Research Ethics in the UK (appendix 24).

Interview participants were provided with an information leaflet (appendices 8-10) prior to the interview. A verbal explanation of the study was also given at the beginning of each interview prior to obtaining written consent (appendix 11). Invited participants were under no obligation to participate and this was made clear to them. In addition they were informed that if they did participate they did not have to answer all questions asked. Furthermore, participants were informed that if they wished any of the content of the transcript to be removed due to concerns regarding their anonymity or any other reason then they could instruct me to do so.

3.8 Reflexivity

Reflexivity is a critical aspect within the social constructionist epistemology; here, the researcher is not considered ‘neutral’, as in the positivistic tradition,

but instead is acknowledged as central to the research (Burr 2003) and a 'co-constructor' of meaning (Morrow 2005).

Stiles (1993) claims that all research stems from personal viewpoints and that these cannot be eliminated, an assertion that coincides with Morrow's (2005, p.254) stance that "qualitative researchers acknowledge that the very nature of the data we gather and the analytic processes in which we engage are grounded in subjectivity", and Taylor's (2001a, p.17) position that "neutrality is impossible because the researcher and the research cannot be meaningfully separated". However, good practice demands that qualitative researchers disclose their known perspectives, assumptions and biases and explain how these subjectivities were managed (Morrow 2005; Stiles 1993; Taylor 2001a). The aim is to "orient readers to the perspectives from which phenomena were viewed and to remind them that this research, like all research, derives from a particular perspective" (Stiles 1993, p.603). Therefore I offer here, within the limitations of personal insight, an explication of my epistemological and ontological perspectives, values, assumptions and potential biases, and the steps I took to manage these subjectivities.

Prior to completing the module on 'Conversation analysis and discourse analysis' my scientific education and work experiences positioned me quite firmly in the positivist epistemology, which Taylor (2001a, p.11) summarises as "... one set of related claims, that research produces knowledge that is universal, in that it holds across different situations and different times, and is value-free". The module on conversation analysis and discourse analysis

introduced me to social constructionism and a completely new way to see language as *doing* something, not just constitutive and a route to people's 'inner essences'. Furthermore my previous orientations that science could provide an objective 'truth' and that good research must be replicable were challenged. The more I researched the social constructionist approach the more I shifted towards this philosophy. Thus my perspectives in undertaking this research were anti-essentialist, seeing language as central to our knowledge of the world and therefore adopting a position where I looked at how people talk about professionalism. This shift was difficult to start with: discourse analysis requires a different way of looking at language, a move away from common-sense reading that is so familiar to us. Nonetheless, with practice I developed my discourse analytic skills, testing my analyses with my academic supervisor particularly in the early days.

In relation to my research topic, I am passionate about professionalism and the provision of high quality care to patients, as well as professionalism towards co-workers, regardless of their position in the organisation. I have high expectations of myself and others to practise professionally.

I have described above my perspectives and values, and next I disclose the assumptions I brought to this research, which are that:

- Pharmacists are the dominant profession in terms of practice and policy;

- Some pharmacists, pharmacy organisations e.g. the RPS, and pharmacy technicians perceive pharmacy technicians as ‘support staff’;
- I am not recognised as ‘equal’ to some pharmacists. This is exemplified by exclusion to certain groups and a different level of pay compared with pharmacist managers.

As a result of these assumptions and my ‘insider’ role as a registered pharmacy technician and senior manager, I am aware that within the positivist epistemology my own perceptions on regulation and professionalism could be seen to create bias and affect replicability of the findings. Whilst the social constructionist approach rejects researcher neutrality and acknowledges that the data collection and analysis methods are grounded in subjectivities, there are steps that can be taken to manage these (Morrow 2005). Being aware of my orientations, values, assumptions and potential biases I was able to manage these subjectivities in the following ways. 1) I kept a reflective diary which included a record of my feelings, experiences and awareness of biases that had arisen, which I discussed with my academic and workplace supervisors. 2) The interview guides were based on the theoretical literature and findings from situational analysis, not purely on my own notions of what was important. 3) I recognised my insider knowledge as something of a double-edged sword in that I am familiar with pharmacy matters and terminology but I may also be too familiar with them and hence needed to ‘pull back’ at times. My research practice was therefore iterative, involving an active and ongoing scrutiny of my own constructs and interpretations. Moreover, I discussed my findings with my academic supervisor, workplace

supervisors and peers, who at times challenged my analyses related to my pre-conceived notions that pharmacists are the dominant profession and that there are unequal relations. 4) The analysis of the interviews included an awareness of my part in the responses obtained; however my own prior understandings were challenged. 5) The sociology of the professions literature provided an external point of reference.

Having acknowledged the potential issues caused by my role and experiences, the positive aspect of this is my 'insider' knowledge and the advantages this brings in terms of questioning what 'outsiders' may not (Hertz 1997). Furthermore, inevitably I am influenced by my knowledge and experiences of pharmacy but that does not deny that the discursive devices used by the interview participants exist in their discourses.

In addition to the steps outlined above, I used a number of measures to warrant the claims I was making, which are described in more detail in the following section 'Warrantability'.

3.9 Warrantability

The conventional notion of reliability (repeatability of findings) and validity (accurate measurement) do not coincide with the social constructionist epistemology where the assumption is that there is not an 'objective truth' out there but instead multiple versions of 'reality' (Potter 1996a; Wood and Kroger 2000).

Wood and Kroger (2000, p.167) assert that:

> *Given the usual understanding of the term validity in relation to truth and in its focus on empirical indices, it would be both confusing and misleading for discourse analysts to talk about validity ...*

Thus alternative ways to warrant claims in discourse analysis have been developed. Wood and Kroger (2000, p.167) claim that "an analysis is warrantable to the extent that it is both trustworthy and sound". They go on to suggest 'criteria of trustworthiness', namely orderliness, documentation and audits. Orderliness in this sense refers to "clarity and orderliness of the way in which the research in all its aspects was conducted and recorded and is reported" (Wood and Kroger 2000, p.169). Documentation requires a "clear description of all facets of the research, including how the data were collected and how the researcher went about doing the analysis" (Wood and Kroger 2000, p.169), and that researchers provide copies of transcripts so that readers can make their own evaluations. Wood and Kroger (2000) go on to identify criteria of 'soundness', namely: orderliness, demonstration, orientation and claim checking. Orderliness here relates to the requirement for analysis and reporting of findings to be orderly. Demonstration is claimed to be the central feature of warranting in discourse analysis as it is "showing how the interpretations of individual excerpts (the subclaims) as well as the overall claims (about patterns and their interpretations) are grounded in the text" (Wood and Kroger 2000, p.170). Orientation refers to "a number of ways that show that this [participant's orientation] is consistent with the analyst's interpretation" and involves drawing on "grammar, content and meaning" (Wood and Kroger 2000, p.171). Lastly, claim checking where "the goal is to

produce a set of claims that accounts for all of the data while acknowledging the possibility of making an argument for more than one set of claims" (Wood and Kroger 2000, p.172). For the purposes of this study, I attempted to meet the criteria of trustworthiness and soundness described above.

Antaki et al. ([no date]) describe six ways that can lead to poor discourse analysis and clarify common requirements no matter the approach to discourse analysis taken. I am aware of the perils and pitfalls of under- and over-analysis described within this paper.

Nixon and Power (2007) have also described a framework to help ensure rigour in discourse analysis. The framework consists of six elements that the authors consider support rigour, namely: having a clear research question; having a clear definition of discourse and the type of discourse analysis; effective use of a theoretical framework; transparency in methods for analysis and application of theory to the analysis; clarity over selection of talk and texts; and, concepts/criteria/strategies to guide the analysis. In addition to attempting to meet the aforementioned criteria of soundness and trustworthiness, and being aware of the pitfalls of under- and over- analysis, I utilised Nixon and Power's (2007) work in attempt to achieve rigour, developing a rigour framework for this study which is provided in appendix 25.

Finally, piloting the interview guide supports reliability but as in any qualitative research the intention is not to carry out research that is replicable (Pope and Mays 2006) but to draw out discourses and gather rich data on what is talked about pharmacy technician regulation and professionalism.

3.10 Summary

This chapter set out the methodology for this research, positioning the discourse analysis approach taken within the social constructionist tradition. Discourse analysis methodology was described outlining four main variants and justifying the broad discourse analysis approach taken for this study, given that the aim is to explore the ways in which pharmacy practitioners talk about professionalism and future practice development in the light of regulation. Eleven interviews were digitally recorded and transcribed, comprising six hospital pharmacy technicians and three hospital pharmacists working in two Health Boards in Scotland, and two Directors of Pharmacy. Since there is no 'recipe' for discourse analysis, the analytic procedures developed for this study were explained. Data categories were described in relation to Stern's (2006) principles of professionalism: accountability, altruism, humanism and excellence, along with the structural aspect of a specialised body of knowledge. Ethical considerations were outlined, and confirmation provided that this study did not require ethical review by the East of Scotland Research Ethics Service. Lastly, sections on reflexivity and warrantability aimed to orientate the reader to my preconceptions and the various activities I undertook to manage my subjectivities and in an effort to ensure rigour.

The next chapter, Chapter 4, presents the findings from this research.

4 FINDINGS

4.1 Introduction

This chapter presents the analysis and the discussion together, contrary to 'conventional' research reports which comprise separate results and discussion chapters (Wood and Kroger 2000).

The focus of this study is the concept of professionalism drawing on Stern's (2006) principles to define the fundamental characteristics of professionalism, along with a consideration of the structural characteristic of a specialised body of knowledge related to preparing pharmacy technicians for professional practice. Thus, to make most sense in the presentation, in accordance with Wood and Kroger (2000), this chapter is set out using the main topic headings of: accountability; a specialised body of knowledge; altruism; humanism; and, excellence. The excellence section is further sub-divided into four parts: ethics; CPD; advancing practice; and, advancing knowledge. Each section within this chapter comprises an introduction, analysis, discussion and summary.

Full interview transcripts are provided in appendices 12 to 22. The following conventions are used in this chapter and/or in the full transcripts:

Participant Titles

Participants are identified by number and a letter to signify their role:

T = pharmacy technician; P = pharmacist**;** D = Director of Pharmacy, e.g. Participant 1T.

Notations

( ) = unclear discourse on the recording and therefore unknown word(s);

(word?) = word(s) within parentheses are a best guess when discourse unclear.

Anonymity

Names, locations and discourse, which if exposed may affect anonymity, are redacted.

Interviewer discourse

This is included in the excerpt where the interviewer interjects and when considered helpful in relation to participants' responses.

Locating the excerpts

Excerpts are identified by participant number and role identifier (P, T or D as above), and the page number of the interview transcript for that excerpt. In the full transcripts the text used in excerpts is highlighted.

Personal pronoun use

To aid anonymity the third person pronoun “she” is used in reference to participants whether or not the participant was female.

A final important point to make prior to presenting the findings is that there is no intention to be critical of participants and imply motivations behind their talk (Harper 2003).

4.2 Accountability

4.2.1 Introduction

Accountability is a key feature of NHS modernisation and of professional practice but it is a complex concept to define in healthcare due to its ambiguous nature (Savage and Moore 2004) and according to Day and Klein (1987, p.26) it is a “slippery, ambiguous term”. Moreover, accountability is often confused with responsibility and even in policy documents these can be used interchangeably (Savage and Moore 2004).

The Department of Health (Great Britain. Department of Health 2010, p.12) defines responsibility as:

> *... a set of tasks or functions that an employer, professional body, court of law or some other recognised body can legitimately demand of a practitioner.*

Whereas accountability:

> *… describes the relationship between that practitioner and the organisation in question. Accountability describes the mechanism by which failure to exercise responsibility may produce sanctions such as warnings, disciplining, suspension, criminal prosecution, or deregistration from professional status. It can be called 'answerability'.*
>
> (Great Britain. Department of Health 2010, p.12)

Therefore responsibility in this definition is considered to be at a 'lower' level than accountability, involving the performance of delegated tasks in an efficient and accurate way. Being accountable is seen in terms of practitioners being answerable for their actions and facing the consequences when something goes wrong, be this from their employer, regulatory body, the criminal court or the civil court.

The GPhC in its 'Standards of conduct, ethics and performance' asserts that:

> *You are professionally accountable for your practice. This means that you are responsible for what you do or do not do, no matter what advice or direction your manager or another professional gives you. You must use your professional judgement when deciding on a course of action and you should use our standards as a basis when making those decisions. You may be faced with conflicting professional or legal responsibilities. In these circumstances you must consider all possible courses of action and the risks and benefits associated with each one to decide what is in the best interests of patients and the public.*
>
> (General Pharmaceutical Council 2012a, p.7)

On the surface the GPhC presents a clear explanation and expectation of individual practitioner's professional accountability and how they should use the 'Standards of conduct, ethics and performance' to support ethical decision making. However there are two main issues with this. First, pharmacy

technicians need to be familiar with the 'Standards of conduct, ethics and performance' if they are to understand their professional accountability and use these standards to help make patient-centred decisions. As will be discussed in Section 4.6, none of the pharmacy technicians interviewed was familiar with the standards and therefore cannot feasibly use them as intended by the GPhC. Second, the literature suggests that where there is a blurring of roles and complementary knowledge bases exist, such as in pharmacy, the confusion over accountability is exacerbated (Eraut 1994; Savage and Moore 2004; Wingfield 2011). The pharmacy technician role has changed considerably over the last 10-20 years, taking on activities previously undertaken by pharmacists, often in an adhoc fashion and shaped by changes in pharmacists' roles. This blurring of roles is confounded by the GPhC (2012a), which does not differentiate between pharmacists or pharmacy technicians in the 'Standards of conduct, ethics and performance' instead using the term 'pharmacy professionals'.

The legal position further confuses the situation: the Medicines Act (1968) requires that pharmacy technicians work under the supervision of a pharmacist, but the term 'supervision' is not defined by statute. Considering that pharmacy practice has changed hugely since 1968 this causes uncertainty in what activities pharmacy technicians can carry out, for example there is a current debate regarding the legality of pharmacy technicians carrying out a final accuracy check on an extemporaneously dispensed medicine. In addition, The Pharmacy Order (2010), which enabled the registration of pharmacy technicians with the GPhC, does not differentiate

between pharmacists and pharmacy technicians in its definition of 'practising':

> *…a person practises as a pharmacist or a pharmacy technician if, whilst acting in the capacity of or purporting to be a pharmacist or a pharmacy technician, that person undertakes any work or gives any advice in relation to the preparation, assembly, dispensing, sale, supply or use of medicines, the science of medicines, the practice of pharmacy or provision of healthcare.*
>
> (Article 3 (2), p.7)

The Chief Executive of the GPhC, Duncan Rudkin (2013, p.3) claims that regulation requires patient-centred professionalism by pharmacy technicians who "have the freedom and support to be able to exercise their professional judgement, and are accountable for their practice".

4.2.2 Analysis: Accountability

Given the lack of awareness of the 'Standards of conduct, ethics and performance', the blurring of roles and the unclear legal position, it is perhaps not surprising that those interviewed reported a lack of accountability amongst some pharmacy technicians, with almost all participants indicating that pharmacy technicians did not all take accountability for their actions.

Participant 1T

Interviewer: And are you accountable for the work that you do and also how you behave?

Both. I think, I mean, yeah, we're accountable for what we do. If we're dispensing a prescription and there's an error made and the pharmacist misses it, and that goes out, we're both to blame I think. Or, if it's maybe sloppy work, or, I don't know. I mean you send out a dosette box and the labels are all squint and you know. It's not wrong, but I think you are

accountable for that, you're accountable for meeting a standard. And so then I suppose then your behaviour, then you are accountable for that. All these things go around if you're caught, I don't know, drunk and disorderly on the street you can be struck off the register and things – I don't know if that's necessarily right but. I think like everything else you are what you do so although I'm not a pharmacy technician when I leave my work, it is still part of who I am so I think your behaviour, well most importantly at work, but then suppose then that would carry on out of work, but you are accountable.

Page 11-12

Whilst this pharmacy technician claims that pharmacy technicians are accountable for their actions and behaviours, she avoids the pronoun "I" and consistently uses "we" and "you". These shifts in pronoun use may appear trivial but this linguistic feature of discourse performs different functions including taking or assigning responsibility (Goffman 1981). In this case the pronoun use works to deflect accountability as an individual construct to one belonging to the profession. The claim that "we're both to blame" (i.e. final accuracy checker and dispenser) if there is a dispensing error is accurate; there has been two court cases where this has been proven (Langley 2013). However when asked if her pharmacy technician colleagues always take responsibility and accountability the response is unfavourable:

Participant 1T

I don't know if it's 'cos I am a DCT so I know bottom line if I've checked something my name is on it. But I have heard a lot of technicians say "well the pharmacist checked it" and give it all the attitude with that. Whereas my reaction would be "oh my goodness I've made a mistake". I think a lot of them don't think they are responsible because they haven't checked it. Maybe not so much now but I know in the past that was generally an attitude, quite "I'm not a pharmacist". I've heard that many times.

Page 12

Firstly this account links being a DCT ([Pharmacy] Dispensary Checking Technician who carries out the final accuracy check on dispensed medicines)

to notions of accountability: “I know bottom line if I’ve checked something my name is on it”. This account corresponds with the RPS and GPhC definitions of accountability although the participant uses the term ‘responsibility’. There is then a comparison with “a lot” of pharmacy technicians who are not DCTs where she has heard “many times” that the pharmacist is considered responsible because they checked their dispensing, highlighting a lack of understanding of the law. Extremisation, where speakers draw on ‘extreme case formulations’ in their descriptions, is a persuasive rhetorical device used to strengthen an account (Pomerantz 1986). This participant’s use of the extreme case formulations “a lot”, “many times” and “give it all the attitude” therefore work to strengthen her case that pharmacy technicians do not take accountability for their actions. The participant then works to make the account more authentic by the use of “I have heard a lot of technicians say “well the pharmacist checked it’”. This device, known as ‘reported speech’ or ‘active voicing’ where a speaker seemingly quotes or paraphrases other speakers, helps to make an account vivid and more factual (Potter 1996b). However she then acknowledges that is “maybe not so much now” implying that the acceptance of accountability has improved.

The following pharmacy technician also uses dispensing errors as an example and whilst claiming to be accountable herself, illustrates a similar scenario to Participant 1T of some pharmacy technicians blaming others for their mistakes:

Participant 4T

No I don't think that all do. They may think, I think maybe in my own area, and you know like dispensing errors and, you know at the end of the day there's an error been made, and, but you know some are "it was because of so-and-so", but you know at the end of the day you made the error. It doesn't matter supposing said to someone "can you get me some Piriton off the shelf", you were responsible for making sure that you had the correct product before you labelled it. So there's maybe individuals who "it's not me" and just other personnel who will put their hands up and "maybe it wasn't actually me" but! So yes, from my own point of view yes.

Page 10-11

This description of responsibility also fits with the RPS and GPhC definitions of accountability: the idiom 'at the end of the day' meaning that in the final analysis an error was made and the person making that error is "responsible". Once again reported speech, for example "it was because of so-and-so", is used to work up facticity and bolster the claim being made that pharmacy technicians do not all take responsibility for their actions (Potter 1996b). The next participant associates responsibility with the developing roles of pharmacy technicians:

Participant 8T

I think more and more that the technicians are being asked to do more and so if they are being asked to do more then they are going to have to take responsibility for what they do, and I think for too long they've hidden behind the pharmacist.

Page 7

This account implies that pharmacy technicians do not currently take responsibility and this is emphasised by the metaphor "for too long they've hidden behind the pharmacist". This conjures up an image that illustrates what the previous two participants described as pharmacy technicians blaming others for their mistakes. This participant, a pharmacy technician,

disassociates herself from this group of pharmacy technicians through the use of the pronoun “they” throughout this excerpt (Goffman 1981). Participant 7T conveyed a different perspective albeit with some caveats about trainees and newly qualified pharmacy technicians:

Participant 7T

I think most of them would take accountability now depending on the level and the different grades but I think they would, I think most of them would.

Interviewer: What do you mean by the different levels and the different grades then?

I think the, the trainees and newly qualified still see it as someone else is looking at this after me, you know, so they are going to take the, if there is anything wrong they are going to, you know they are going to be the ones that are on the dock, I’m not going to be standing up there in the court witness box. Because we use that one with them as well: “You’ll be standing beside me when I’m standing up there, you know, getting stricken off or whatever you’re going to be there beside me”. “Ah but you checked it”. There is still a little bit of that mentality there that you’ve checked it so it’s all your responsibility. It’s not, and once they are registered you say that to them as well, you are registered, you are taking responsibility. I think that just takes a wee while to get into them.

Interviewer: And it is all new isn’t it, it has only been since July.

Some of them, some of them are very young. Some of them are straight from school at 17, 18. They can’t take responsibility for themselves! Yeah I think it comes with time and age.

Page 15

The seriousness of dispensing errors is stressed with the reference to standing “on the dock”, “standing up there” and being “stricken off”. Reported speech, in “you’ll be standing beside me ... you’re going to be there beside me” and “ah but you checked it”, works to make the account factual (Potter 1996b). Whilst this participant says that most pharmacy technicians would take accountability, once again this sense of their work being ‘double-

checked' is reported to affect trainees and newly qualified pharmacy technicians' impression of accountability. This is justified by some of them being "very young" and accountability coming with "time and age".

The Directors of Pharmacy were at odds in their accounts of pharmacy technicians' accountability.

Participant 1D

I think both pharmacy technicians and pharmacists think a lot of the accountability lies with the pharmacists.

Interviewer: yeah, still?

Still, still. It's, it's, there's work to be done there.

Interviewer: Yeah, OK. And what do you think would help with that, is it some of the things we've already talked about?

Yeah some of the things I've talked about in terms of clarification about where accountability and responsibility lies. And, and, and I think it's better to do it now when you're not, there's no kind of, you know, fatal accident inquiries or anything. 'Cos that, you know, 'cos the only other way it will get clarified is through the law and in court ... And, and, and well you want to be prepared for that.

Page 16

This Director claims that there is an issue regarding accountability as "both pharmacy technicians and pharmacists think a lot of the accountability lies with the pharmacists". Whilst purporting that there is a need to address this lack of clarity as the alternative is a fatal accident inquiry and "through the law and in court", she distances herself from responsibility for this through her pronoun use of "you're" and "you want to be prepared for that" shifting the responsibility onto the pharmacy technician profession (Goffman 1981). The

other Director was more favourable about the current situation around pharmacy technicians' sense of accountability:

Participant 2D

I, I think yes on the whole I would think that there is a, a, a, a large cohort of that group who would understand, or do fully understand sorry, their responsibilities and accountabilities and would see that through on a daily basis. You know, I, I, I do think there'll be a certain element in there of "I can pass it onto the pharmacist "or "I can pass it on to someone else". So there's, again I suppose it's like any profession, there's probably a little bit of variation in there just now but I, I don't sit here and think, you know, we've got a technician group who are abdicating responsibility when it suits or, you know.

Page 7

This account utilises minimisation and extremisation devices (Pomerantz 1986); the extreme case formulations "a large cohort" and "fully understand their responsibilities and accountabilities" work to make the strongest case that pharmacy technicians take responsibility and accountability for their actions. Those who do not are minimised with "a little bit of variation" which is then normalised with "like any other profession" which is therefore difficult to argue against.

Since regulation brings with it accountability (General Pharmaceutical Council 2012a), I was interested to explore participants' accounts on whether or not regulation made a difference to pharmacy technicians' acceptance of accountability. All but one participant asked about this gave a positive account that regulation should make a difference to pharmacy technicians' perceptions of accountability, in concordance with the findings in Bradley et al.'s (2013) study into skill mix in community pharmacy whereby the four

professional groups interviewed considered regulation brought with it an increased requirement for accountability.

Participant 1T

I think it should change it because we've all had to meet a certain standard to be registered, and that whole point of regulation I suppose is to know that we are all trained to that same standard, so we all need to uphold that standard. And I think the fear of, fear's maybe not the right word, but the fact that if you do something, whatever it may be, to not meet that standard and you are held accountable for that, I think that may make people sit up and think "oh I actually am accountable". And it might go a way to sort of make people feel what they do does matter and it is important and they are not just sticking a label on a box or putting tablets in a bottle they are, they have got a professional job.

Interviewer: It'll be interesting to see how that pans out then.

But then I think education will play a high part in that but people have to, because you've maybe got people who have maybe been in the job for 20 years and think, well I've always done this job what difference is it going to make, and that's going to be hard I think. A lot of people don't like change and we've had a lot of change recently. And a lot of the change has not been to benefit us in any shape or form so how is this going to make any difference. And getting that round to people I think is going to be.

Page 12

Participant 1T relates accountability to meeting a standard and the repercussions if one does not, and how the awareness of that may be a revelation to some: "that may make people sit up and think 'Oh I actually am accountable'". The use of reported speech works to make this assertion factual (Potter 1996b). She then goes on to identify the need to educate pharmacy technicians about accountability and describes why getting acceptance of this is problematic for "people", particularly for those who have "maybe been in the job for 20 years". This is then justified by there being a perceived lack of benefit to pharmacy technicians. This participant is seen to shift between the external "people" to include herself in "we've had a lot of

change recently" and "a lot of the change has not been to benefit us in any shape or form ..." before shifting back to "getting that round to people is going to be ...". This shift illuminates a potential dilemma: the difficulty in accepting accountability is directed towards 'others' but "we've" and "us" sandwiched in between these assertions about "people" implies that this refers to herself as well. Extreme case formulations "lot" and "any shape or form" are persuasive rhetorical devices that work to strengthen the case being made (Pomerantz 1986).

Participant 4T also raised the problem with pharmacy technicians unable to see personal benefits from regulation and that it would take time to realise their accountabilities:

Participant 4T

Yeah, I suppose it is new for a lot of them still, you know the ones who have just registered. Yes I think through time. And you know, as things integrate, happen and you know you are now a registered professional you are accountable for your, you know, for what you do. If it's feeding that back to them you know when you go over things, it's up to me you know to include that in the discussion.

I think through time, you know, realising you know, what it is actually all about. I think they just see at the moment, oh, you know, a hundred-odd pound and I get nothing for it but it's all about more than that

Page 11

Participant 9P also presented the passing of time as an important aspect of pharmacy technicians' understanding of accountability but related this to the punitive aspect of regulation:

Participant 9P

Yes I think it will. I think it's difficult just now but a few years down the line there will be the expectation that pharmacy technicians that fall outwith the Code of Ethics will be picked up by the Society, will be picked up by the Pharmaceutical Council.

Page 13

Another pharmacist reported the importance of accountability for pharmacy technicians:

Participant 10P

Yes I mean it's worth, certainly being regulated means they are professionally accountable which I think is the, is the biggy. I think for technicians themselves that's a big thing, you know, that you are now professionally accountability for what you do.

Interviewer: Do you think technicians understand that at the moment from your experience or would you not know?

You know I don't know, it's too new. I mean there was a lot of mumping and moaning about it, an awful lot of mumping and moaning about it when it came out and I thought well, I'm not being sympathetic here, you know! You know. We have to be accountable, and signed up and, you know, and I think that's it that, I think the technicians are really taking on what used to be the traditional pharmacist's role. We were professionally accountable when we dispensed a prescription and let it go, so, you know.

Interviewer: They should be too?

They should be too.

Page 16-17

Extreme case formulations "biggy" and "big" and the repetition regarding pharmacy technicians now being professionally accountable strengthen the claim made here that regulation brings accountability (Pomerantz 1986). In common with the pharmacy technician accounts above, the time aspect is highlighted in "it's too new" but there is little sympathy shown regarding the "mumping and moaning" experienced with this, justified by "technicians are

really taking on what used to be the traditional pharmacist's role. We were professionally accountable when we dispensed a prescription and let it go, so, you know".

4.2.3 Discussion

The GPhC has made clear the requirements for professional accountability, and whilst pharmacy technicians interviewed claimed that they were accountable for their practice, rhetorical features such as pronoun use of 'we' and 'us' rather than 'I' may imply that there is still a nervousness about accountability for some, which was also a finding by Bradley et al. (2013) in their study about pharmacy skill mix. Furthermore, all participants' descriptions included that pharmacy technicians did not all take accountability for their actions, although this ranged from a minority (Participant 2D) to a lot (Participant 1T) and the justification given for this was experience and age, for example: "Yeah I think it comes with time and age" (Participant 7T); and, "Yes I think through time" (Participant 4T).

It is doubtful that age and experience will be accepted as a justification for errors in a court of law. The two criminal cases referred to earlier in this section involved a pre-registration pharmacist in one case and a dispenser, who is not a qualified pharmacy technician, in the other, along with the pharmacists who carried out the final accuracy checks. The first case, known as the 'Peppermint water case', arose when a pre-registration pharmacist chose the wrong strength of chloroform water to extemporaneously prepare

peppermint water for a baby and the pharmacist did not notice the error. The baby was given the preparation and died as a result. The pre-registration pharmacist and the pharmacist were originally charged with manslaughter however, two years later on the day of the trial this was altered to an offence under Section 64 of the Medicines Act 1968 and both received a fine after pleading guilty (Langley 2013). In the second case, known as 'The Prestatyn case', a patient was dispensed Sertraline (an anti-depressant) instead of Spironolactone (a diuretic) by the dispenser. The pharmacist did not notice the error and this patient also died after taking the Sertraline tablets. The pharmacist and dispenser were convicted under Section 64 of the Medicines Act 1968. The dispenser contested the conviction but was unsuccessful as the Magistrate's Court concluded that the she played a key part in the supply of this medicine. It was acknowledged that the pharmacist was more qualified and senior but the dispenser was still judged to be guilty (Langley 2013). Whilst work is underway, entitled the 'Rebalancing Project', which is reviewing medicines legislation and regulation and involves proposals to decriminalise dispensing errors, pharmacy technicians and pharmacists who make unintended dispensing errors would still be liable to professional regulation through the GPhC in relation to their fitness to practise (Anon. 2014a).

Some participants highlighted the relationship between getting one's work checked by another when dispensing and how this negatively affects perceptions of accountability. Those who were qualified to carry out the final accuracy checks on dispensed medicines realised their accountability e.g. Participant 1T said " ... I know bottom line if I've checked something my name

is on it but I have heard a lot of technicians say 'well the pharmacist checked it'". This acknowledgement of accountability by qualified accuracy checking pharmacy technicians was also found during the situational analysis phase of this study, and may be associated with pharmacy technicians no longer 'hiding behind the pharmacist'.

A further potential explanation for pharmacy technicians' apparent lack of willingness to take accountability may be one put forward by Batey and Lewis (1982) who claim that accountability is inextricably linked with responsibility, authority and autonomy. They define responsibility as "a charge for which one is answerable" (Batey and Lewis 1982, p.14) which is similar to the Department of Health definition provided at the start of this section i.e. "... a set of tasks or functions that an employer, professional body, court of law or some other recognised body can legitimately demand of a practitioner" (Great Britain. Department of Health 2010, p.12). Authority is defined as "the rightful power to act on a charge" and autonomy as "freedom to decide and act" (Batey and Lewis 1982, p.14 and p.15). On the other hand, the Royal College of Physicians (2005) decided that autonomy is an outdated construct in medical professionalism because it "suggests the right to self-governance, an appeal to personal authority – that is, the right to pursue a practice that is entirely self-generated. Clearly, that is not a value we wish to recommend" (p.16).

In a different vein, Eraut (1994) argues that whilst it would be natural to expect that more autonomy would equal more accountability the opposite is

perceived because “Accountability has been presented to professional workers more as an external control mechanism rather than a strengthening of their moral and professional obligations: and hence as a threat to autonomy rather than as a consequence of it” (p.225). Whether that is a perception of pharmacy technicians, it would still seem that it is important to have autonomy and authority in order to be accountable. According to a Royal College of Nursing report (Savage and Moore 2004), if autonomy and authority are lacking, and education does not prepare professionals for accountable practice, it makes it complex and difficult for professionals to actually be accountable. This query over education and training preparing professionals for accountability is also produced by Walsh (2012) and Savage and Moore (2004) in relation to the type of training received i.e. competency based training which stresses obedience and following orders. The current entry qualification for pharmacy technicians is competency based training with underpinning knowledge and therefore falls into this category.

Harrison and Pollitt (1994) also purport that where there are organisational hierarchies any disagreements about accountability often result in disagreements about control. In the nursing profession, the development of the ‘Scope of Professional Practice’ has been accredited with clarifying the accountabilities of nurses and, as a result, enabling role development (Savage and Moore 2004) as it does not codify roles but instead provides principles for adjusting nurses’ scope of practice (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1992).

Participants reported that regulation should make a difference to pharmacy technicians' professional accountability, but that there was a lack of awareness amongst pharmacy technicians of their accountabilities. Interestingly, none of the participants mentioned that pharmacy professionals are accountable for their omissions as well as their actions. In addition, as found by Savage and Moore (2004), the terms responsibility and accountability were used interchangeably by participants indicating a lack of understanding of the difference between these two terms.

Clarification of responsibilities and accountabilities of pharmacists and pharmacy technicians, as identified as a requirement by one of the Directors of Pharmacy, has also been identified as a requirement by other commentators (Bradley et al. 2013; Great Britain. Department of Health 2014; Middleton 2006; Pharmacy Law and Ethics Association 2014; Wingfield 2011). Indeed, many professional conduct cases are due to lack of awareness and uncertainty over accountability (Savage and Moore 2004) and therefore it seems critical for all concerned that clarification of accountability is forthcoming.

4.2.4 Summary

The outcomes that are clear from the above discussion are the requirement for clarification over the legal accountabilities of pharmacy technicians and pharmacists, and the need to increase the awareness of what professional accountability means amongst pharmacy technicians. A 'Scope of

Professional Practice for Pharmacy Technicians', similar to that produced for nursing, could be beneficial to clarify accountability and, as a result aid development of extended roles. In order that pharmacy technicians can legitimately be held accountable there also needs to be consideration of their autonomy and authority in the workplace, along with a review of the entry level qualification: how can pharmacy technicians practise as accountable professionals if their training does not help prepare them for this? The next section explores pharmacy technicians' education and training in relation to the professional characteristic of a specialised knowledge.

4.3 Specialised Body of Knowledge

4.3.1 Introduction

This section of the chapter comprises two central aspects: a specialised knowledge and the initial education and training for pharmacy technicians. Each of these themes is presented, followed by an analysis and discussion. A summary in relation to a specialised body of knowledge concludes this section.

A specialised knowledge enabling a unique role is a common feature of the professions irrespective of the theoretical approach (Cruess, Cruess and Johnston 2000; Eraut 1994; Johnson 1972; Larson 1977; Saks 1999; Traulsen and Bissell 2004; Witz 1992). However there is criticism in the literature that the term specialised knowledge has not been adequately defined in terms of length or depth of specialism (Larson 1977). Moreover,

Lorentzon (1992) highlights the difficulty in defining knowledge for one profession due to the greying of task boundaries between occupations, giving nursing and medical knowledge as an example although similarities can be drawn between pharmacy technicians and pharmacists. Middleton (2006) in her article 'What will it mean for technicians to be part of a profession?' questions if pharmacy technicians do have a unique body of knowledge or is their knowledge base "a 'watered down' version of a pharmacist's unique knowledge base" (p.412); this could be likened to Etzioni's notion of 'semi-professions'.

Middleton (2006) goes on to suggest that pharmacy technicians require a distinct scientific knowledge base from that of pharmacists and provides examples of safe working systems, computing and robotics. This proposal to define a distinct knowledge base has been used as a professionalising strategy for other healthcare disciplines, for example nursing has been identified as an occupation that developed its own clinical base to differentiate between nurses' roles and that of doctors' (Harrison and Pollitt 1994) and to improve professional status (Hallam 2002; Witz 1992).

4.3.2 Analysis: Specialised Knowledge

In the present study, during the interviews some interviewees were asked directly did pharmacy technicians have a unique role/specialised knowledge and others were asked to describe the pharmacy technician role in general terms. The Directors of Pharmacy were asked the question directly and

claimed that pharmacy technicians do have expert knowledge / a unique skills set, although Participant 2D confines this to pharmacy technicians working in secondary care i.e. hospitals.

Participant 1D

Right, so if we look at the first one which is do they have expert knowledge, yes they do. I'm pretty comfortable with that one actually.

Page 2

Participant 2D

Where I still think there's a little bit of mentality in the, in the community pharmacy which would be, "the pharmacist is the most important person and we are just there to support the pharmacist", and I don't see it as that in secondary care absolutely not. I think it's a, it's about going back to everyone's got their unique skill set and I, I wouldn't expect pharmacists to do the majority of jobs that technicians do to the same standard, as well as them, as quick as them 'cos that's the unique professional skill set they've got.

Page 7-8

The first excerpt by Participant 1D is explicit in the assertion "yes they do", emphasised by "I'm pretty comfortable with that one actually". Participant 2D also presents a strong case for pharmacy technicians having a unique role, utilising a number of discursive features to do so. The use of reported speech "the pharmacist is the most important person and we are just there to support the pharmacist" works here to convey an alternative view whilst distancing herself from it (Potter 1996b), and then using the extreme case formulation "absolutely not" to bolster the claim and further emphasise the different practice in secondary care (Pomerantz 1986). The three part list contained within "I wouldn't expect pharmacists to do the majority of jobs that technicians do to the same standard, as well as them, as quick as them" is a rhetorical device that emphasises an activity or event as common place

(Jefferson 1991) and here works to further substantiate the uniqueness of the pharmacy technician's role.

In contrast to the Directors of Pharmacy accounts that pharmacy technicians do have unique roles but more in accordance with Middleton (2006, p.412) who considered pharmacy technicians' knowledge base as "a 'watered down' version" of pharmacists, of two participants specifically asked if pharmacy technicians have unique roles, one pharmacy technician disagreed and the other, a pharmacist, provided a dilemmatic "yes and no" response.

Participant 12T

No I don't think pharmacy technicians necessarily are the only ones that can do their job. I think you would have to be quite ( ) to think that. No, I don't think so, I think other people could do, do the role.

Page 9

Participant 10P

It's a bit of a difficult one. I mean, yes and no? If that makes sense. Yes in that the way that the pharmacy team, the pharmacy service has developed is that the pharmacists are now, you know, definitely more clinical based and using their knowledge in that way and, you know, moved very much away from the actual assembly and preparation of medicines and that is now very much the technicians that, that do that, so in terms of, in terms of procurement, certainly the procurement and dispensing aspect then that really is all technician driven, you know, and aseptic, TPN.

Interviewer: So that kind of supply chain?

Supply chain and assembly is now very much technician led. But it's not that the pharmacist couldn't or wouldn't do that but. You know if all our technicians went off sick tomorrow we'd have to go in and do that, now that would be interesting 'cos we'd probably have to hand write the labels 'cos there's probably not enough of us that have, you know, a reasonable enough level of knowledge to label a prescription off the system. So that's what I mean by yes and no, you know it's not a unique skill because pharmacists have that skill, or had that skill, they just no longer practise it routinely so. So I mean, but then in terms of contingency plan yes there would be an issue if all the technicians went off, you know, a day off sick I don't know quite how we would.

Interviewer: OK, yes, that's interesting.

I mean there's SOPs that we would all need to get out and follow but

Interviewer: Aha, yes, you can do it but.

We wouldn't do the work as quick. And I would be concerned about, there would definitely be an increase in terms of risk.

Page 12

Participant 10P expresses an explicit dilemma in the first sentence with "It's a bit of a difficult one. I mean, yes and no?" The extreme case formulations (Pomerantz 1986) "definitely" and "very much" strengthen the claim that pharmacists' roles have developed to a clinical role, moving away from the supply chain which has become the pharmacy technicians' domain. The dilemma is explained by "But it's not that the pharmacist couldn't or wouldn't do that". However what follows this claim is a number of caveats: "we'd probably have to hand write the labels 'cos there's probably not enough of us that have, you know, a reasonable enough level of knowledge to label a prescription off the system ... yes there would be an issue if all the technicians went off, you know, a day off sick I don't know quite how we would … And I would be concerned about, there would definitely be an increase in terms of risk". So, whilst there is the assertion that "you know it's not a unique skill because pharmacists have that skill, or had that skill, they just no longer practise it routinely", the use of "had that skill" and "just no longer practise it routinely" may account for the difficulties then expressed.

Participant 10P's description of the pharmacy technicians' role as a technical/functional specialism in that it encompasses the supply chain of medicines was consistent with other participants' accounts, as follows:

Participant 1T

I would say dispensing was the main thing, whether that is aseptic dispensing ... but yeah I would say dispensing and distribution of medicines is the core of a pharmacy technician's job. The pharmacist's role would obviously be more the medicines, the drugs side of it for each specific symptom or condition. The technician kind of just slot into these departments but I think we are more focussed on providing the medicine that is asked for.

Page 9

Participant 4T

It's to do with getting medicines to the patient safely, and getting it right first time ... But I think if you were just to strip it right down certainly getting the medicines to the patient, making sure it gets there and it's right, and its right first time. You don't get second chances.

Page 8-9

Participant 7T

It's very diverse the pharmacy technician job so it is quite hard to put it into sort of one sort of sentence or paragraph, it's quite hard because there are so many different ones. But I suppose it is to see the safe supply of medication to patients

Interviewer: Yeah that is really good actually

Because that would cover just about the chemo, TPN, out on the wards as well as dispensary.

Page 11

Participant 9P

So they'll have a bit of, bit of time up on the wards maybe doing a bit of clinical, bit of speaking to the patients, like organising all their medicines for them, doing their medicines on admission, speaking to the GP, through to working in, in the dispensary, (seeing to?) the hatch, doing all the labelling and dispensing, the sort of nuts and bolts thing that pharmacy needs to survive. Because ultimately you can put as many people on the wards as you

want, unless you've got, unless you've got a tech in distribution feeding them the medicines you are also going to regress to that, that point of procurement and supply, which is our basic thing that we need to do.

Page 9

The following account by a junior pharmacist was somewhat vague and there is an apparent dilemma over the role of the pharmacist and the role of the pharmacy technician:

Participant 5P

So, I guess there's a lot of things which pharmacists do which, is there the question of whether it actually needs. But out-patients it does. I think that what a pharmacy technician cannot, not that they can't do it but that they are not qualified to do it. Because any clinical aspects that technicians pick up on, on discharge prescriptions, but that's all part of clinically checking a prescription but they don't have the qualifications ... It's difficult because if I was to check a discharge.

Interviewer: So a proper professional clinical check on it

Exactly and I guess the ward technicians do that if they were to check a home visit what the patient had on pre-admission with the medicines reconciliation form but there is always an element of a pharmacist double checking. It always depends on how much trust you have in them because at the end of the day you are the one so unless there are errors … but then what would a pharmacist ever do, I don't know.

Page 5-6

This account commences with a suggestion that pharmacy technicians may be able to carry out many of the roles currently undertaken by pharmacists before to-ing and fro-ing between what pharmacy technicians can and cannot do implying a dilemma. Regarding the ward role the amount of "double checking" undertaken by the pharmacist depends on how much "trust you have in them" but this is explained by "at the end of the day you are the one" implying that the pharmacist is accountable if the pharmacy technician makes a mistake. The explicit dilemma "but then what would a pharmacist ever do, I

don't know" indicates an issue with role differentiation and the potential threat to pharmacists' roles should pharmacy technicians' roles advance in ward areas, but it also highlights a lack of a concurrent strategy to developing pharmacists' roles.

4.3.3 Discussion

Work carried out by the Scottish National Acute Pharmacy Services Group (NAPS) (2012) produced a skill mix vision for hospital acute pharmacy services. This included that pharmacists' focus should be on providing pharmaceutical care and that pharmacy technicians take responsibility for the supply chain of medicines. Since the interviews for this research took place and the NAPS work was completed, 'Prescription for Excellence' (Scottish Government 2013a) was published. This strategy requires that all pharmacists will be independent prescribers by 2023, working across hospital and community settings to deliver person-centred pharmaceutical care. To release pharmacists' capacity to achieve that aim 'Prescription for Excellence' expects there to be "full utilisation of pharmacy technicians" (Scottish Government 2013a, p.9). In essence this provides a strategy for hospital pharmacists' role development into independent prescribers who provide pharmaceutical care to patients where it is needed, and to do that pharmacy technicians are required to take responsibility for the safe supply of medicines to patients. A report commissioned by the Royal Pharmaceutical Society (2013), 'Now or Never' also strongly recommends the shift in focus for pharmacists from dispensing and supply to the provision of pharmaceutical

care, utilising pharmacy technicians and technology as enablers. Therefore the descriptions given by many of the participants above regarding a unique role in the safe supply of medicines to patients fits well with the NAPS skill mix vision (2012), and the strategies presented in 'Prescription for Excellence' (Scottish Government 2013a) and 'Now or Never' (Royal Pharmaceutical Society 2013). Nonetheless, the apprehension expressed by Participant 5P "but then what would a pharmacist ever do, I don't know" has been identified as an issue in recent work reported at a Department of Health workshop on optimising pharmacy skill mix (Great Britain. Department of Health 2014). Here, it was reported that there was a reluctance by pharmacists to relinquish control and that "many pharmacists are 'protecting' their role as they can't see where they are moving to next" (Great Britain. Department of Health 2014, p.3). This may explain why the role development of pharmacy technicians across Scotland is so varied, with some Health Board areas still heavily reliant on pharmacists to carry out roles that pharmacy technicians should be doing to meet the NAPS skill mix vision and 'Prescription for Excellence'.

The NAPS group is currently carrying out a mapping exercise across Scotland to identify the present position related to the skill mix vision so that the gaps and training requirements can be established and plans put in place to try and address these. However appropriate role development also requires leadership at local levels to describe the vision for pharmacist and pharmacy technician roles and responsibilities and to put steps in place to ensure the shift happens.

Whilst a unique role for pharmacy technicians has been identified, a further area of interest is whether or not the current qualification required for entry to the GPhC register adequately equips pharmacy technicians for professional practice.

4.3.4 Analysis: Initial Standards of Education and Training

As pointed out at the beginning of this section, specialised knowledge as a feature of professionalism has not been clearly defined (Larson 1977); however, most regulated healthcare professions are educated to degree level (Nairn 2007). Whilst some pharmacy technicians have attained degree qualifications, the entry requirement for registration as a pharmacy technician is the N/SVQ Level 3 in pharmaceutical sciences with recognised underpinning knowledge, for example the National Certificate in pharmaceutical sciences. The Directors of Pharmacy were asked if this level of training adequately prepares pharmacy technicians for professional practice.

Participant 2D gave accounts at different points of the interview that are relevant to this topic, and these are shown below as three separate excerpts:

Participant 2D

I agree with you I think there's definitely something of, you know building that broader knowledge base and that confidence that comes with that.

Page 26-27

... and you know it would be good, it would be interesting to see what other models could be explored around the, the education. You know with regards to whether it's a more degree type teaching you know, combined with, it's, it's difficult, it's difficult.

Page 28

So, I mean I, I would be very supportive of, of whatever we could do, you know, at any level, particularly national level to influence that workforce plan. And if we can do something around getting in particularly, I think you're right about influencing the qualifications.

Page 32

The extreme case formulations used in "I would be very supportive ... whatever ... any level" strengthen the positive nature of the account (Pomerantz 1986). In the second excerpt, "it's difficult, it's difficult" may illustrate an explicit dilemma but this may be with regard to progressing any change to the qualification as it was followed by my response: "It is difficult. And I think what we've done is handed over to NES now to say 'Look this is what we need pharmacy technician's to do, how, you do that bit of what does the qualification look like".

The other Director of Pharmacy was asked if the current SVQ Level 3 training was sufficient in terms of developing critical thinking, decision making and analytical skills associated with making professional judgements:

Participant 1D

I think that's a really interesting question because, you know Hamish Wilson. Yeah, you know him, Hamish Wilson, he's the guy that has just done the Wilson review for pharmaceutical care.

Interviewer: Yes, I have heard of the Wilson review.

Yes, but this was way before Hamish did that. So, basically Hamish was the Director of Primary Care at the Scottish Government and before that he was Director of Primary Care in Grampian. He's an incredibly bright man, so he's

got like a double first in history and something else from Oxford or Cambridge. And he's really nice and you know these men who are incredibly bright and they just see things more clearly? He has a view that professionals over qualify themselves.

Page 9

In the above excerpt the participant does not directly answer the question but instead uses category entitlement to warrant category-specific knowledge to Hamish Wilson (Potter 1996b). This description of Hamish Wilson's career history and educational attainments set him up as an 'expert', bolstering the critical account that follows:

Participant 1D

And it's almost self serving. It's not what's needed to do the job for others but it, it helps them and enhances their own self esteem. And when he said it I was really, you know, I was, and I think it's true of pharmacy and others you know, pharmacy degrees, and now masters degree dah de dah de dah. And I was you know, I was trying to stand back and I was thinking is he right? Is he right? Do, do, is this attainment of qualifications what we use as a badge to justify our professional position and I think we do do that inappropriately. Maybe that's partly because that's how society judges us in some ways but I think if we really concentrated on what is the role of the profession which is actually about the needs of the public, then I would be less inclined to go for more qualifications and more inclined to actually critically review practice. And actually think about what it is we are trying to achieve for patients as opposed to individual qualifications.

Page 9-10

In the above discourse, the questions "is he right, is he right?" and "is this attainment of qualifications what we use as a badge to justify our professional position" signifies that this Director of Pharmacy initially had doubts about Hamish Wilson's 'expert' opinion but then concurs with him in her later statement "I think we do do that inappropriately". The use of 'expert' corroboration and the questions of doubt may be considered as 'stake inoculation' (Potter 1996b) to counter any potential allegations that the

Director of Pharmacy made these claims on any grounds of self interest. The above excerpt concluding with “And actually think about what it is we are trying to achieve for patients as opposed to individual qualifications” could be construed as a criticism towards pharmacy technicians wishing to increase the level of qualifications required to practise as self-interest over the needs of the public. The next excerpt follows on from the above response:

Participant 1D

Interviewer: Yeah, OK. Yeah that’s really interesting actually because I think where I was coming from was thinking about the difference between sort of SVQ level 3 training where you’re really more trained by rote and graduate, sort of degree level where it’s much more about, so I think, you know for technicians it’s, they’re taught something and they, that’s the way they do it where as for degree level it’s more, it’s more the general principles and you apply it do you know what I mean? I am probably not explaining that very well.

No you’re absolutely right, and that, that is what critical appraisal is about and actually you’d think a professional group should be doing some of that. I’m trying to suggest that I think that if you started to look at your practice then you would start to critically appraise your practice and you would develop those skills through that route.

Page 10

The Director of Pharmacy again does not directly answer the question but instead emphasises that a review of qualifications is not required by offering an alternative route to developing critical appraisal skills.

The Idis Pharmacy Technician Pharmacy Education Programme (no date) defines critical thinking as:

> *You are able to apply the knowledge that you gained during your qualification and work experience to new situations. You know how to evaluate the different sources of information, and decide which are credible. If you are faced with conflicting pieces of information you know how to assess the quality of each source of information and*

weigh up the evidence in order to make a judgement about the most appropriate way forward.

(Page 11)

How pharmacy technicians then learn to critically appraise their practice is unclear as the current entry level training does not include any teaching on critical appraisal.

4.3.5 Discussion

One Director of Pharmacy gave a supportive account regarding the need to review and raise the entry level qualification for pharmacy technicians, using extreme case formulations (Pomerantz 1986) to strengthen the claim that there is a need for "building that broader knowledge base and that confidence that comes with that". However, the other Director of Pharmacy, although not explicitly disagreeing, can be seen to 'warn off' pharmacy technicians from raising the qualification due to self-interest and that instead we should "... actually think about what it is we are trying to achieve for patients as opposed to individual qualifications". Eraut (1994) also acknowledges that increasing the length of training has been used by some professions as a professionalising strategy and cautions against this, advising that the length of training should be based on requirements for competence and not to gain professional status.

Nonetheless, it can be concluded that the literature supports that the current level of training does not equip pharmacy technicians for professional

practice: the difference in the level of education for certificate or diploma level compared to graduates is primarily around the development of critical thinking, decision-making and analytical skills (Milligan 1998, cited in Girot 2000, p.331). The competence training currently undertaken by pharmacy technicians prepares them to work in the current context of their practice, whereas graduates develop deep-thinking strategies and are prepared to practice autonomously in an ever-changing environment (Cooper 2005; Girot 2000). Lorentzon (1992) reports on a study undertaken by Robinson, Strong and Elkan (1989) and refers to a quote by research participants:

> *Existing ways and means of providing nurse education are traditionalistic, narrow, often unimaginative and expensive. This is not conducive to producing nurses capable of critical thought, independent judgement and innovative behaviour.*
>
> (Robinson, Strong and Elkan 1989, p.65, quoted in Lorentzon 1992, p.16)

Currently pharmacy technician training remains traditionalistic: it has not changed significantly for over 20 years whilst the roles and responsibilities have changed massively, and since 2011 pharmacy technicians require to be registered to practise. The entry level qualification for pharmacy technicians requires review so that it is 'fit for purpose'. The GPhC's 'Standards for the initial education and training of pharmacy technicians' state that "the curriculum must remain relevant to current practice and national standards" (2010a, p.10). To enable delivery of safe, effective and patient-centred care, the Scottish Government's 2020 Workforce Vision (2013b, p.5) requires that everyone "has the skills needed, including professional, technical and people skills".

Whilst the entry level qualification for pharmacy technicians has been reviewed over the years and additions have been made, very little has been removed resulting in a qualification with a large knowledge base that is a challenge for the Colleges to teach and, as a result, reduces the time spent teaching the relevant aspects for current practice. Moreover, there are core roles missing from the entry level qualification that employers require pharmacy technicians to be able to carry out from day one of practice such as final accuracy checking, medicines management roles including assessing patients' own medicines and taking medication histories, and aspects of professionalism (National Acute Pharmacy Services 2012). Herrera (2010), in her PhD research evaluating foundation degrees for pharmacy technicians in England, claims that the current minimum qualification to register does not adequately prepare pharmacy technicians for these 'new' roles and that this has raised fears for patient safety. Updating the entry level qualification would also support development of a 'Scope of Professional Practice for Pharmacy Technicians' to enable clear accountability for role development without the need for certification to prove competency, as discussed previously in Section 4.2 Accountability.

In the nursing profession Project 2000, developed by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and implemented in 1989, started the movement of nursing training to degree level (Harrison and Pollitt 1994). This shift in educational standards for nurses has been identified as a factor for greater professionalism (Harrison and Pollitt 1994; Rafferty 1996). Moreover, Bottero (1994 cited in Harding, Nettleton and

Taylor 1994, p.26) claims that the Royal Pharmaceutical Society increased the level of the entry level qualification and period of training for pharmacists as part of its professionalisation strategy.

Paramedics registered with the Health Professions Council (now the Health and Care Professions Council) in 2003, with the entry requirements being a course of study equivalent to a Certificate of Higher Education for Paramedics (Health and Care Professions Council 2014). However, the College of Paramedics ([no date], p.1) states that "During the past decade Higher Education Institutions (HEI's) have developed Paramedic Science programmes in partnership with Ambulance Services that **exceed** the HCPC academic entry level …" (emphasis added). There is then a description of the acceptable education programmes at the level of foundation degree or diploma of higher education, Bachelor of Science or Bachelor of Science with Honours. Studies on paramedical training suggest that paramedics should be graduates to equip them with the knowledge and skills required to work in today's health service (Cooper 2005; Kilner 2004). Furthermore, that degree-level education is a requirement for credibility with other regulated professions (Cooper 2005).

It is interesting that the paramedics' professional association decided to exceed the entry level set by the regulatory body. During work undertaken by the NAPS group in Scotland to identify the education and training needs for pharmacy technicians, the GPhC, which sets the standards for initial education and training for pharmacy technicians, reported that the entry level

qualification was the minimum standard and that if desired, in Scotland it could be raised to include the gaps that had been identified by NAPS. This would require agreement and approval by the Directors of Pharmacy for Scotland and there may be resistance to this, particularly if it is seen as self-serving rather than in the best interests of patients, as Participant 1D cautioned.

4.3.6 Summary

If the Directors' accounts are accepted, due to their strategic and leadership roles for the pharmacy profession in Scotland, and the requirements under 'Prescription for Excellence' (Scottish Government 2013a) to better utilise pharmacy technicians' skills are also considered, then pharmacy technicians have a unique role with responsibility for the safe supply of medicines to patients, and thus can be regarded to have a specialised knowledge. However the NAPS group has established that this 'unique role' is at different stages across Scotland with some areas still relying heavily on pharmacists to carry out roles that should be done by pharmacy technicians. The gap analysis being undertaken by the NAPS group will identify the current situation but it will require national and local leadership to make the changes happen. Further, the dilemmas illuminated in this study regarding the role of the pharmacist should pharmacy technicians have a 'unique role' were also expressed in the Department of Health report on pharmacy skill mix (Great Britain. Department of Health 2014). Here, it was reported that pharmacists

are loathe to relinquish current roles because they do not know what will take their place.

The entry level qualification for pharmacy technicians requires review so that it is 'fit for purpose', enabling pharmacy technicians to meet professional requirements and also to meets employer's requirements. This is not for self-interest but as a requirement to deliver pharmacy technicians with the knowledge and skills for professional practice in modern day pharmacy.

Within the theories of the professions, specialised knowledge is claimed to put professions in a position of 'power' over patients and the public, and it is altruism and ethics that protect patients from professions using this power for self-interest (Beaton 2010). The next section explores pharmacy technicians' and pharmacists' accounts of altruism.

4.4 Altruism

4.4.1 Introduction

Altruism is one of the three common attributes the commentators in the sociology of the professions tend to agree on (Millerson1964, p.5, cited in Johnson 1972, p.23). Altruism can be described as a behaviour based on empathy (Batson 1990, cited in McCamant 2006, p.337) and compassion (McGaghie et al. 2002), characteristics that are associated with caring healthcare professionals. Moreover Beaton (2010) emphasises that altruism and ethics are required in order for patients to trust professionals due to the

asymmetrical knowledge which gives professions power over the public. Considering contemporary professionalism and the drive for patient-centredness in healthcare, along with the GPhC's 'Standards of conduct, ethics and performance' requiring patients to be "your first concern" (General Pharmaceutical Council 2012a, p.6), altruism can be deemed a fundamental attribute for professional practice.

Participants were asked questions around their own feelings of altruism and/or if their pharmacy technician colleagues demonstrated altruism.

4.4.2 Analysis: Altruism

Many participants referred to altruism as 'going that extra step': working late and through tea-breaks, generally 'putting themselves out' in the best interests of patients. Pharmacy technicians who were asked this question all indicated that they themselves were altruistic but their accounts implied that this was not the case for all of their pharmacy technician colleagues.

Participant 1T

No I would say absolutely. I mean it's simple things like you're supposed to finish at a certain time but if you've got a dosette box that needs to be done, you wouldn't, or I certainly wouldn't and I don't know many technicians that would say "well I'm going home". You wouldn't leave anything half finished or anything that was needed because your time was up, I don't know if that … Or if it came to maybe, I know many times you don't have a tea break because you've got so much that you need to get done or an order needs to be put through or something's not right, or there's maybe a drug discrepancy and you've got to stay back to sort out and I think yeah you would put the profession or the person before yourself.

Page 10-11

This participant uses a number of extreme case formulations to bolster her claims of altruism: “I would say absolutely”, “I certainly wouldn’t”, “many times you don’t have a tea break because you’ve got so much that you need to get done ...”. The use of reported speech in “I don’t know many technicians that would say ‘well I’m going home’” helps to work up facticity of the claim (Potter 1996b). Lastly the three-part list, which can contain more than three items, whereby the type of activity that requires one to work through a tea break is listed e.g. “an order needs to be put through or … something’s not right, or there’s maybe a drug discrepancy …”, works to construct this eventuality as common place (Jefferson 1991) so further bolstering the claim made that she is altruistic.

Participant 4T

Yes I think that is true about, of myself and a lot of my colleagues you know within our department. I think we are, there’s a lot who will go that extra step you know

Page 10

The use of “a lot” in this account implies that there are some pharmacy technicians who will not “go that extra step” and hence are not altruistic.

Participant 7T

I think you become like that yeah.

Interviewer: Yeah, you do?

Yeah. Because daily people do things ( ). They will come in and do ( ) put patients first a lot of the time.

Page 13

Participant 7T describes altruism as a process in the statement “you become like that”. In accordance with Participant 4T, the word choice in “put patients first a lot of the time” implies that either pharmacy technicians are not altruistic all of the time or not all pharmacy technicians are altruistic.

Participant 12T

Well I mean certainly in where we are with cancer patients I would say yes we do put the patients first. ‘Cos if I was in their position I would like to think that somebody you know was putting me first before say well I need my lunch break or I need to get home at 5 o’clock or whatever.

Interviewer: Yeah, so that whole kind of seeing something through for the patient rather than I’m due to go home or take a break.

No I certainly wouldn’t do that and I don’t think anybody would that was working in our area.

Page 10

In this account Participant 12T uses the emotive category of “cancer patients” to ‘justify’ the need for altruistic behaviour, repeating this with “I don’t think anybody would [go home or take a team break] working in our area”. The extreme case formulation (Pomerantz 1986) “certainly” works as a persuasive device to further strengthen the claim of altruism amongst those working with cancer patients.

The following participant is explicit that not all of her colleagues are altruistic:

Participant 8T

I’d dearly like to say yes knowing I’m not going to have to, I’m not going to be able to say yes because I personally think it’s human nature, it’s just how you are. And you’ll, and there will be some people who will be very professional in their job, and will get everything just right and, but at the end of the day they can walk away at 5 o’clock and not think about it. Which maybe is a

professional thing to do. Whereas there are others who will stay that bit longer and they will go that extra because they care about what they are doing and they care about the people at the end of it.

Page 12

"I'd dearly like to say yes" in this account works as a disclaimer (Hewitt and Stokes 1975), a rhetorical device used prospectively in this case to protect the speaker from being typified as negative about her peers' altruism prior to making the substantive claim that "it's human nature". One can still be professional in other aspects but those who "go that extra" do so because they care.

In opposition to pharmacy technicians mostly favourably accounts regarding their own altruism, pharmacists, whilst describing the pharmacist profession as altruistic, finishing what they were doing or working late in the best interests of the patient, portrayed pharmacy technicians as having a lack of patient focus or knowledge of the 'bigger picture':

Participant 5P

If we were working you know and if there is out patients waiting we will finish what we are doing. The needs of the patients coming before the need to beat rush hour traffic. So, it's different when you are in (clinical?) everyone follows everyone, different time, or making sure you have a full hour for lunch because if we're involved in something and you end up staying there 'til late, it's just what happens. So I would say in some areas, so there isn't a big everybody is leaving now. Whereas you do get that in dispensary. But sometimes I do think that on wards you're, you see the patient, when you are in the dispensary you do not so I don't think you see the needs of the patient and maybe if everybody got a chance to they would probably make more of a connection of dinner or does the patient get his medication.

Page 8

The pronoun use of “we” in “if we were working ... we will finish what we are doing” appears to refer to pharmacists, who are portrayed as putting patients first, bolstered by “it’s just what happens”, which works to convey this as a normal occurrence and an immutable matter of fact. This is contrasted with the dispensary staff where there is a “big everybody is leaving now”, this being blamed on the role rather than the individuals; those in dispensary-based jobs lack connection to the patient as the patient is ‘unseen’ on the ward. The following excerpt from another pharmacist also ‘blames’ pharmacy technicians’ roles for a potential lack of altruism:

Participant 10P

I don’t know whether this is fair or not but I’d say, that, maybe it’s just the way we have worked and the service has developed that the technical staff tend to be a lot more, just because of the nature of the role that they play, you know process driven, SOP, this is the way we do it and this is how we do it, and you know that kind of outcome and may not look at the bigger picture in terms of the patient and the, yeah if that makes sense.

Page 13

This pharmacist uses a number of disclaimers in “I don’t know if this is fair or not”, “maybe it’s just the way we have worked” and “just because of the role that they play”. This type of disclaimer is termed ‘hedging’ and can be used when a speaker is uncertain how an account will be received and therefore what type of response she will get and how she will be perceived. The disclaimer prospectively highlights the tentative nature of the forthcoming account and demonstrates a preparedness to be persuaded otherwise (Hewitt and Stokes 1975). Nonetheless the claim is that pharmacy technicians may not see ‘the bigger picture’ and therefore lack patient focus.

The next participant initially presents altruism as person-dependent before going on to describe it as a behaviour that can be learnt:

Participant 9P

I think it's all a very mixed bag. I think it depends on the person really. I'd like to think all of them had the patients' best interests at heart, whether or not they started off that way or not, but certainly they should have already gleaned that sort of feel from the, the people round them and they should have, they should have the patients as number one focus by now even if they didn't start off that way. ... And, you know, the patient focus builds along with that knowledge and experience and almost by what you are expected to do by other people in your job and what is expected from the patients you meet at the hatch or at the bedside.

Page 11-12

Participant 9P's account presents the culture as important in 'building' altruism even if people "didn't start off that way".

One Director of Pharmacy was very clear that altruism as "a public service ethos" was "really important" whereas the other gave a very hesitant account about the notion of altruism and its place in the modern NHS.

Participant 1D

So I see altruism and I suppose I see that in terms of this, a kind of a, a public service ethos. I think that's really important whether it's the health service or law, whatever, you're, you're there to serve others and it's quite an old fashioned view and I still believe in it. I still believe that, that we, we should be there to serve. We are given a privileged position within society and that we should be very grateful for, that privileged position and it, it's not a right, and I think that, I still don't think I see enough of it in technicians or pharmacists. It, it's that whole kind of, your accountability should be to each of your patients and you should be putting their needs above everything. And almost like speaking as a manager I should be hearing more people say "well this is not good enough, our patients deserve better", I'm not hearing enough of that to some extent. I'm hearing "this is what the system is, this is what the bureaucracy says should happen.

Page 12

Throughout the interview this Director of Pharmacy consistently refers to patient-centredness over self interest therefore it is unsurprising that she describes altruism as an important attribute for healthcare workers. The need for a public service ethos is emphasised with the use of extreme case formulations “really important” and “putting their needs above everything”, along with the repetition of professionals as having a “privileged position”. The use of reported speech “well this is not good enough, our patients deserve better” and “this is what the system is ... bureaucracy says should happen” works to make the account stronger and more vivid (Potter 1996b). Of note is the construction of an ‘either/or’ dichotomy: you are either patient-centred with a public-service ethos or you are not, which makes the need for altruism difficult to argue against.

Participant 2D

Yeah. Not sure about the relevance. What, what are you thinking there I’m just, I’m just, obviously you’ve looked at these models and, just trying to think of.

Interviewer: Yeah. Well just you know, does it, does it really matter if people are coming in here to do, or you know become a Pharmacy Technician or a Pharmacist or whatever profession for the community, for the good of the community rather than for the good of themselves you know is it, does that really matter or is there other reasons that people go into it and they can still be professional but without being, that, always putting others in front of themselves. Is that important?

Yeah, it’s a difficult one that isn’t it?

Interviewer: Yeah. I’ve had a variety of answers to that

Yeah. I mean I, I think, yeah I’m probably sticking with my original answer. I’m not sure, quite sure if it is that relevant in, now in, certainly, and certainly where I think we should be going in terms of a modern NHS, you know I don’t think there is that, I don’t think that trait needs to be that strong, if you, if you like

And I would hope that's linked in to probably what I've said this morning you know in terms of other, of my other views.

Interviewer: Yeah other aspects

And other aspects of it. But yeah I don't, I don't, I wouldn't say that, that, that, that's, that is particularly relevant, no. No I, yeah. It's hard to, I'm trying to think, the reason I asked that other question is I was trying to kind of picture it in some kind of different types of scenarios almost about that, trait, behaviours and how that might apply and.

More narrative then:

You know, so I think it's, I think keeping it simple I think the answer to the questions is that I, I feel it's probably not particularly relevant as where we would want to be. Yeah.

Page 32-34

This Director of Pharmacy is explicit in acknowledging this question about altruism as challenging with the use of "It's a difficult one that isn't it?" and "It's hard to ...". This difficulty is exemplified by the use of numerous qualifications throughout these excerpts such as "probably", "not quite sure" and "particularly relevant" which create vagueness and uncertainty. Harper (1999) claims that such qualifications accomplish a useful defence in the face of a challenge as the speaker can respond that this was a tentative proposition. Word repetition, for example "what, what are you thinking there", "… if you, if you like", "I don't, I don't, I wouldn't say that" and "I wouldn't say that, that, that, that's, that it is particularly relevant" also indicate hesitation and uncertainty.

Whilst some participants have claimed altruism is 'a way of being', so one is either altruistic or one is not, some depict pharmacy technicians as lacking altruism due to the roles they undertake and others directly suggest that

altruism is a construct that can be learnt, which was also a claim made by the other Director of Pharmacy:

Participant 1D

Interviewer: But, going back to the altruism then, do you think that's something that either people have or they haven't got? Is it something you can teach? Or learn?

OK, OK, so that's really important, I think you can. See I think you can. I do believe that some people are more altruistic than others, that's you know, and we would hope that those people who have those inclinations are attracted to public sector roles. So I would hope that there's kind of almost like that, people see that that fits with their, but I do actually think you can. Because we actually get people in at quite a young age and so they come in at eighteen to be technicians. They're not adults yet. You know, I don't think they're adults until they're 25, I think you can actually mould people quite a lot, you can expose them to things. You know, if they are cruel, nasty individuals and they're all, you know, there's not much you can do about that, but I just (hope?), I think you can shift, there's that, you can do that 10% shift which makes, which makes, which may make a critical difference. And I do think you can do that.

And, and it's actually about, it's about, it's not just about altruism but it's about empathy and so forth as well and actually, many people will not have experienced some of the difficulties and the stressful times that people have within a hospital environment 'cos they are so ill themselves. So when they come in first they won't know anything so we need to teach them about that. What, what is the right way to behave in those circumstances and how do you support people in those circumstances and what's your job around that and I think you can. I think you can. You can, you can either grow people around that or you can shut it down and just allow a negative culture to exist.

Page 14

Participant 1D's use of extreme case formulations "really important" and "critical difference" (Pomerantz 1986) along with the repetition of "I think you can" make a strong case for the claim that altruism can be taught. This Director of Pharmacy also links empathy with altruism which is consistent with Batson's (1990) empathy-altruism hypothesis whereby Batson purports a relationship between an empathetic emotional response and altruistic behaviour.

4.4.3 Discussion

The recent literature supports the notion that altruism is an essential attribute of healthcare professionals (General Pharmaceutical Council 2012a; Scottish Government 2012) and reports such as the Mid Staffordshire NHS Foundation Public Inquiry (2013) and the Keogh (2013) review highlight the requirement for compassionate care.

Participants commonly constructed altruistic behaviour around notions of working late or working through lunch breaks in order to get medicines to patients. Whilst the pharmacy technicians interviewed claimed that they themselves were altruistic, they conveyed that not all of their colleagues were. This was either implied through their word selection i.e. “I don’t know many technicians that would say ‘well I’m going home’” (Participant 1T), “a lot who will go that extra step” (Participant 4T), and “ ... put patients first a lot of the time” (Participant 7T), or explicitly as in Participant 8T’s account: “I’d dearly like to say yes knowing … I’m not going to be able to...”.

Pharmacists’ accounts described a lack of altruistic behaviour amongst pharmacy technicians and blamed this on their lack of patient focus; working in a department-based role, for example a dispensary, means that pharmacy technicians do not see in-patients and are therefore removed from them, seemingly unaware and unresponsive to patients’ individual needs. These accounts of altruism highlight that there is potentially a development need amongst pharmacy technicians. In accordance with some of the participants’

reports, the literature would suggest that altruism is not a fixed trait and is therefore malleable and a construct that can and should be taught (e.g. McGaghie et al. 2002; McCamant 2006).

As an emerging profession the lack of professional socialisation is likely to be a factor in any lack of altruistic behaviour amongst pharmacy technicians, and therefore encompassing the need for altruism right from the recruitment stage, during early education and on throughout careers will help pharmacy technicians to learn to be altruistic and for this to be reinforced and supported on an ongoing basis. In addition, the traditional department-bound roles for pharmacy technicians places a barrier between them and patients and in my own experience the development of ward-based roles for pharmacy technicians has made a significant difference, improving patient-centredness and flexibility in service delivery. With 'Prescription for Excellence' (Scottish Government 2013a) demanding the better utilisation of pharmacy technicians to release pharmacists' time and the NAPS group's vision for hospital skill mix (2012) it should only be a matter of time before ward-based roles are common-place for all pharmacy technicians, enabling patient-centred behaviour.

4.4.4 Summary

Altruism is considered a valuable core characteristic for healthcare professionals (Stern 2006) and the General Pharmaceutical Council's (2012a) 'Standards of conduct, ethics and performance' require that all pharmacy

technicians make patients their first concern. Whilst the pharmacy technicians interviewed portrayed themselves as altruistic, rhetorical features and explicit discourses suggest that this is an area for development amongst pharmacy technicians. The lack of professional socialisation along with the department-based roles of pharmacy technicians can be seen as contributory factors, which could be addressed by the development of direct patient-care roles on wards and an emphasis on the requirement for altruistic behaviour from recruitment, during training and on throughout individual's careers.

Altruism, although identified as a separate construct by Stern (2006), is closely linked to humanism (Beaton 2010; Cruess, Cruess and Johnston 2000), which will be explored next.

4.5 Humanism

4.5.1 Introduction

According to the nursing, midwifery and allied health professions in Scotland, the concept of humanism includes respect, compassion, empathy, honour and integrity (Scottish Government 2012). These aspects of humanism were not explored directly in this study, but the preparedness of pharmacy technicians to challenge others or raise concerns about behaviours was discussed, and this is what forms the basis of the analysis for the humanism principle.

The Health Select Committee (2011) emphasises the obligation that healthcare professionals have to report concerns about standards of care, the impetus being high-profile cases such as 'The Shipman Inquiry' (2005) and the 'Public inquiry into children's heart surgery at Bristol Royal Infirmary' (Great Britain. Department of Health 2001). As a result the GPhC produced 'Guidance on raising concerns' (General Pharmaceutical Council 2012b) to help pharmacy practitioners understand their responsibilities, provide advice on the steps they could take to raise a concern and, if in a management position, deal effectively with concerns raised to them by staff. The 'Guidance on raising concerns' is based on principles within the GPhC 'Standards of conduct, ethics and performance' (General Pharmaceutical Council 2012a).

Section one of the 'Guidance on raising concerns' draws attention to the importance of raising concerns:

> *Every pharmacy professional has a duty to raise any concerns about individuals, actions or circumstances that may be unacceptable and that could result in risks to patient and public safety. You have a professional responsibility to take action to protect the well-being of patients and the public. Raising concerns about individual pharmacy professionals, the staff you work with (including trainees), employers and the environment you work in is a key part to this. This includes raising and reporting any concerns you have about the people you come into contact with during the course of your work, including pharmacists, pharmacy technicians, pharmacy owners, managers and employers, other healthcare professionals or people.*
>
> (General Pharmaceutical Council 2012b, p.6)

In addition to the raising concerns guidance from the GPhC, all Health Boards should have a local 'whistle blowing' policy in place. The Francis Inquiry (Mid Staffordshire NHS Foundation Public Inquiry Report 2013) and Keogh (2013)

review also highlight the requirement for all healthcare staff to raise any concerns about patient safety and well-being.

4.5.2 Analysis: Raising Concerns

Regarding raising concerns, the interview questions were mainly framed around pharmacy technicians challenging pharmacists, for example about dispensary practice, rather than specifically on raising a concern. Excerpts from other parts of the interview transcripts have been included in this section of analysis where the discourses were considered relevant e.g. in relation to questions about experiences of unprofessional behaviour.

Pharmacists were asked if pharmacy technicians challenge decisions made by pharmacists.

Participant 5P

But ask what they have been told to do in the dispensary and that's, so little things like that, that as a pharmacist I'll ask them to do it but quite often you just get told "no, this is what we have been told to do". And to be honest I am quite happy with that because there is a dispensary procedure then there's a reason for it being decided and obviously that's, you know. But I still think the decisions have to be made and if you really want it to be changed.

Page 7

A category entitlement is employed by this participant in the use of "as a pharmacist". Category entitlements are rhetorical devices whereby particular categories of people in certain contexts are assumed to have certain knowledge or skills that do not require any further explanation (Potter 1996b).

In this context, “as a pharmacist” conveys the pharmacist as one knowledgeable and therefore entitled to be ‘obeyed’. This participant also uses a conversational structure known as a three part concession (Antaki and Wetherell 1999): here, “as a pharmacist I’ll ask them to do it” forms the ‘proposal’. This proposal could be challenged or not well received and so the participant makes explicit her awareness of that (the concession) in “And to be honest I am quite happy with that because there is a dispensary procedure and there’s a reason for it being decided ...” prior to reprising the original proposal “but I still think the decisions have to be made and if you really want it changed”. This three-part concession draws awareness to the participant’s recognition of the need for SOPs but then rebuts this, which works to make the original proposition stronger (Antaki and Wetherell 1999).

It is interesting that the pharmacy technicians are reported as doing “what we have been told to do” rather than, for example, this is the way it should be done. This, along with the category entitlement of “as a pharmacist” and the three-part concession accomplish a portrayal of pharmacy technicians in a submissive position even although the participant describes pharmacy technicians as being able to challenge when they disagree with a request.

Participant 9P relates the ability to challenge with experience and therefore it’s a “mixed bag”:

Participant 9P

Some would, yes.

Interviewer “but some wouldn’t?

Some would, some wouldn’t. I think you’ve got a mixed bag. It depends on how confident somebody is.

More narrative then:

Interviewer: I suppose what I’m trying to find out is do you think pharmacy technicians will challenge others or will it depend what position they are in, you know, are they kind of frightened off because they think other people ...?

It very much depends on the person, their experience and their logic behind why they are challenging something. If somebody feels very strongly about (x?) you know.

Interviewer: And I suppose that could be the same for pharmacists or any profession as well.

Absolutely. There’s, there’s pharmacists that will challenge things a lot based on their experience, how bolshie they are sometimes as well, their experience of the situation. How confident they are in the, the evidence they have to back up their argument as well. And It’s no different (with pharmacy technicians?) or even assistants. I’ve had assistants question why I’m doing things and I’m quite happy to explain, you know, and I would expect people to question why I am doing things so they can understand.

Page 10-11

The “mixed bag” is explained by the ability to challenge being down to the individual and their confidence, experience and logic and that this is like any other profession. Similar to the pharmacist Participant 5P, the notion of ‘the pharmacist knows best’ is portrayed here with “I’ve had assistants question why I am doing things and I’m quite happy to explain ... so they can understand”. The ‘challenge’ appears to be because they do not understand rather than it being a legitimate challenge.

The following pharmacist’s account also starts with a suggestion that being able to challenge requires experience:

Participant 10P

I mean I think that comes with experience as well, you know as a pharmacist now, I mean sort of, you know, early on in my career I would never have dreamed of challenging half the things I do now with the consultant...

Interviewer: If the consultant says.

Whereas now I'm quite happy on the ward round with clinicians to actually, you know, challenge or suggest something else or to ask or to say "why are you doing this?" you know.

Interviewer: So it is a bit about experience as well as your own kind of personality?

Which I suppose is something in terms of professionalism with the registration of the technicians that probably gives them a better, a better platform now, you know, to do that, I think in terms of their, in terms of their own work.

Interviewer: I think it should do but I don't know whether it actually does or not?

Yes it should but whether it does. Yes, you do. Yes I think technicians generally are reticent to speak up or to point out if they think something, something's not right.

Page 10

This pharmacist refers to her own experience in developing the ability to challenge comfortably and the time aspect in "early on in my career I would never have dreamed of challenging ... now I'm quite happy on the ward to ... challenge". However she then shifts onto the notion of professionalism and how that gives technicians "a better platform ... in terms of their own work". This may imply that registration means that pharmacy technicians are accountable for their own work and therefore 'justified' to challenge pharmacists decisions. However, on prompting, this participant concedes that pharmacy technicians are "reticent" to challenge, which is consistent with an account by a Director of Pharmacy:

Participant 2D

I mean I, I see technicians in here challenging the pharmacists occasionally. And I think it's more probably when I came in, you know and it's something I've really actively encouraged about, you know through the way that we have the system, you know so if you take the dispensary and they have the regular huddles throughout the day and there's, and you know, there is that very clear roles and responsibilities and I think the technicians do challenge. I think the technicians if, if I'm being honest though, would like, or feel that if they were reflecting, could challenge more. And that is a confidence thing. You know and, and, and you go back to the professionalism bit, you know that is a key element of that. You know so what I said at the beginning about recognising, you know, what is good practice, thinking about the patient, and then if they feel that it could be improved, how do I address that? You know whether that's with the doctor, the pharmacist, and yes everyone will seek advice and think about the best way to do things in a real life environment but there's something there about having that professional responsibility and confidence to challenge.

Page 27

From saying that pharmacy technicians challenge pharmacists "occasionally" at the start of this excerpt the Director of Pharmacy, after describing the work done to support pharmacy technicians, then states that "I think the technicians do challenge". However this claim is then offset somewhat: "to be honest" works to reluctantly assert that pharmacy technicians could challenge more but the footing changes so that the assertion is positioned with pharmacy technicians in "technicians ... would like, or feel if they were reflecting, could challenge more", rather than with the speaker (Edwards and Fasulo 2006, cited in Tseronis 2011, p.482). This works to remove the Director of Pharmacy's agency and therefore responsibility for this claim (Goffman 1981). The professional responsibility to challenge others in order to improve practice in the best interests of patients is made.

There was variance in the pharmacy technicians' responses to questions about challenging with the most senior pharmacy technicians giving the most

confident response. Junior grades said they did not really feel in a position to challenge pharmacists, although one then went on to give an example of when she had done so:

Participant 4T

Interviewer: ... just say you are in the dispensary and you have got someone working there and, maybe a pharmacist, but they are doing something that's not right, or against procedure would you challenge them in that or would ?

Yes.

Interviewer: You would? Because of your role then?

Yep, yep. Yes I would, yes, I would do. You know, if they argued with what I said, or you know continued to ... but yes, you know I think my role allows me to do that. With more junior technicians, not, they'll come to me.

Page 12

Whilst initially presenting a confident account of challenging the pharmacist in this scenario, "if they argued with what I said, or you know continued to..." implies that this participant may back down in that case. The level of seniority of the pharmacy technician is presented as allowing a challenge rather than this being an expectation of any pharmacy technician.

Participant 7T

I would, I would challenge to a certain degree, then if they, depending on the time of day it is happening, you know, if it's out of hours or if I am there at the time or just hear about it afterwards, I would push it up a level to make sure that my manager knew that it happened and that either I'd challenged at the time or I'd spoken to them after to say it's inappropriate. Yes I would, yes.

Interviewer: Do you think that's something that all pharmacy technicians feel confident in or do you think is that because of the position you are in?

Maybe because of the position that I am in. Then other people with lesser confidence might come and say to me about it if they didn't feel that they could ( ).

Page 16

Again this reasonably confident account from a relatively senior pharmacy technician (dispensary manager) is then qualified with “to a certain degree” and “I would push it up a level to make sure that my manager knew ...” suggesting a lack of confidence or authority. Further, pharmacy technicians are once again portrayed as lacking confidence to challenge directly. This is consistent with accounts from more junior pharmacy technicians:

Participant 1T

If I wasn’t being required to do anything that I didn’t think was right, and I have come across pharmacists who would make decisions and do things that, I’m like I don’t think that’s right, that’s not the way to do it. But if they want to do it and it’s just them, then no I wouldn’t challenge them. But if I had concerns about like repeated behaviour of a pharmacist or a senior technician higher than me or whatever I would find the right person to voice it to. But no, I wouldn’t think it was my place to say to them you shouldn’t be doing this.

Page 13

Here, the notion of ‘not my place’ is raised: as long as it does not involve this participant doing anything wrong then the pharmacist can do what they wish unless there was “repeated behaviour” which would be reported. When asked for a description of unprofessional behaviour at a different point in the interview, this participant responded:

Participant 1T

I was in doing a POD screening patient’s medicines and writing up orders for them and there was a nurse and a clinical support worker making a patient’s bed and the wee lady was sitting in a chair beside the bed, and they were having a filthy conversation, over the bed as they were making the bed, in a bay of six ladies, who are elderly. And just what they were talking about wasn’t professional, it was just filthy. And I, I never said anything as I didn’t feel it was my place to say but I just thought, one, if that was my granny I wouldn’t be pleased and the fact that they didn’t seem to have any decorum of just, or even the way like, the way they speak to them sometimes.

Page 5

The participant provides a detailed description of the scene which helps to construct the account as factual (Potter 1996b): the speaker is conscientiously carrying out her role as a pharmacy technician, whilst the nurse and clinical support worker have a "filthy conversation". "Filthy" is then repeated, emphasising the unprofessional nature of this discussion. The description of the patients as a "wee lady" and "... ladies, who are elderly" invokes a category entitlement. Potter (1996b) claims that membership of a category imputes members with certain characteristics, and in this case the category of "elderly" ladies suggests the requirement for respect, a key element of professionalism. Once again this participant "didn't feel it was my place" to challenge the unprofessional behaviour. This assertion along with the description of her own conscientiousness works to absolve the speaker of any responsibility for this situation.

The following account is similar to Participant 1T in that pharmacists "get it done the way they want" with the caveat "unless it's completely off the wall" or "completely contrary" to the SOP:

Participant 12T

Interviewer: ... if a pharmacist came in, who might be a quite senior pharmacist or not, and they said I don't like it being done that way, for me I want it done that way, or for the patient I want it done that way. Would you challenge that and do you think other people would?

Not usually, I mean it does happen that pharmacists come in saying they want it done this way and if they are checking it then they get it done the way they want. Unless it was completely off the wall or it was completely contrary to SOP you had then it would be explained to them that we can't do that ... but if it's just a quirky sort of labelling issue or whatever, it would be changed to the way they wanted it rather than cause a …

Interviewer: so even if best practice is.

Yeah but if they are checking then it would be done like the way they wanted it.

Interviewer: But if it was something that you thought was unsafe?

Oh I would challenge that.

Page 11

The extreme case formulation "completely" emphasises the scope available to pharmacists to deviate from procedure although this is then qualified with "if it's just a quirky sort of labelling issue", with "just" working to minimise this as an issue (Pomerantz 1986). The justification for not challenging these requests is that the pharmacist is performing the final accuracy check on the dispensed medicines. However this participant did respond that if a practice was unsafe she would challenge that, and indeed went on to give an example of this:

Participant 12T

Interviewer "Do you think other technicians would with the same experience or less experience?

Probably not. I mean we did have it here a few years ago when we had a pharmacist working in aseptic and our accountable pharmacist was on maternity leave and she came in and she was absolutely useless and she had no, no idea what was going on, she was unsafe.

Interviewer: that would be difficult for you.

Aye, so we went to our site lead and said it's unsafe practise and I can't work with this person, she shouldn't be there. At first he thought it had been a personality clash - I don't have a personality clash with folk I mean I've worked with that many! I said "you know I don't think it's safe". Then it came to light, I mean I kept documenting it and nothing was getting done and then the accountable pharmacist came back and she was "Oh my God this is terrible". I said "terrible, I've been here and I've documented everything". At one point she fiddled the documentation before [name removed] signed it and got rid of it. Eventually she, she didn't get sacked but I mean she had a court case on

the go at the time, but she's away now and I don't even think she practises any more, she's not on the register. It was very uncomfortable but I challenged just about everything that she, because she was, she was unsafe.
Page 12

Extreme case formulations (Pomerantz 1986) "absolutely useless" and "no idea", along with the repetition of "unsafe" practice bolster the assertion that this pharmacist was unsafe. This assertion is then corroborated by an 'expert' in the reference to the accountable pharmacist and also by the use of reported speech "Oh my God this is terrible" (Potter 1996b). Again extreme case formulations are used, "terrible" and "documented everything", to emphasise the seriousness of the situation (Pomerantz 1986).

4.5.3 Discussion

As identified at the beginning of this section, the GPhC makes clear that pharmacy practitioners have a duty to raise any concerns in relation to patient and public safety, including raising and reporting concerns about colleagues (General Pharmaceutical Council 2012b). Regulation brings with it professional responsibilities and obligations and there are three standards within the GPhC 'Standards of conduct, ethics and performance' (General Pharmaceutical Council 2012a) that relate to raising a concern:

> ***Standard 1.2****: You must take action to protect the well-being of patients and the public*
>
> (p.8)

> ***Standard 2.4****: You must be prepared to challenge the judgement of your colleagues and other professionals if you have reason to believe that their decisions could affect the safety or care of others*
>
> (p.9)

> ***Standard 7.11****: You must make the relevant authority aware of any policies, systems, working conditions, or the actions, professional performance or health of others if they may affect patient care or public safety. If something goes wrong or if someone reports a concern to you, make sure that you deal with it appropriately.*
>
> (p.16)

My personal experience has highlighted that many pharmacy technicians are unaware of the 'Guidance on raising concerns' (General Pharmaceutical Council 2012b) and the 'Standards of conduct, ethics and performance' (General Pharmaceutical Council 2012a), the latter also being a finding in this study and discussed in the forthcoming Section 4.6 on ethics. Although participants in this study were not asked directly about raising a concern, a question about pharmacy technicians challenging pharmacists or unsafe practice established two broad repertoires. First there was the notion of 'the pharmacist knows best' and pharmacy technicians going along with pharmacists' individual 'quirks'. Second was the need for confidence or experience to challenge others, with this ability being associated with the seniority of the role. There was also recognition by some that this was the case for all professions. Of the junior pharmacy technicians' accounts, one utilised a 'not my place' discourse in reference to challenging unprofessional behaviour, whilst the other gave an example of having challenged unsafe practice, although her report did not appear to be taken seriously until it was corroborated by the accountable pharmacist.

4.5.4 Summary

Pharmacy technicians' lack of knowledge of the 'Guidance on raising concerns' (General Pharmaceutical Council 2012b) and the GPhC 'Standards of ethics, conduct and performance' (General Pharmaceutical Council 2012a) should be addressed so that pharmacy technicians understand their professional responsibilities and obligations in relation to patient safety. In addition, workplaces should endeavour to equip staff to intervene or speak to their manager to raise concerns. Moreover, managers require training to ensure that they deal effectively with concerns that have been raised with them, maintaining confidentiality and following due process so that staff have confidence in them to deal with their concerns in an appropriate manner.

The next section comprises four different subdivisions which are related to the principle of 'excellence': ethics; CPD; advancing practice; and, advancing knowledge. Each section consists of an introduction, analysis, discussion and summary.

4.6 Excellence: Ethics

4.6.1 Introduction

The GPhC, the regulatory body for pharmacists, pharmacy technicians and registered pharmacy premises in England, Scotland and Wales, has defined 'Standards of conduct, ethics and performance' that registered pharmacists

and pharmacy technicians must follow (2012a). Furthermore, during the annual registration renewal process every registrant is required to make a renewal declaration which includes the terms:

> *With the exception of matters already notified to the General Pharmaceutical Council, I have and will adhere to the standards relating to conduct, ethics and performance and continuing professional development published by the General Pharmaceutical Council.*
>
> (General Pharmaceutical Council [no date] c, p.2)

4.6.2 Analysis: Ethics

None of the pharmacy technicians asked if they were familiar with the GPhC 'Standards of conduct, ethics and performance' reported that they were, but features of their discourse illuminate this as a dilemma for them:

Participant 1T

Yeah I think I printed it off to be honest. But I don't know, I haven't actually really studied it but yes, I have heard of it.

Interviewer: OK, then maybe familiar with it and what it's about?

No.

Page 12

A number of rhetorical devices are used in this short account. "To be honest" can be used "to convey a kind of reluctance on the speaker's part to be saying what they are saying" (Edwards and Fasulo 2006, p.344, quoted in Tseronis 2011, p.482). The participant uses the conditionals "think" and "I don't know", which introduce vagueness (Turnbull and Saxton 1997, in Wood and Kroger

2000, p.211). Further, “I don’t know” can also be used where the “speaker’s interest is likely to be of particular concern” (Potter 1996b, p.132). These rhetorical devices suggest a dilemma; the participant realising she should be familiar with the standards however conceding “But ... I haven’t actually really studied it but yes, I have heard of it” before ‘admitting’ that she was not familiar with it or what it is about.

There were similarities in Participant 4T’s account:

Participant 4T

Not particularly familiar with. You know, I have not read it you know cover to cover. It has probably been spoken about, you know, how we behave, you know how we conduct ourselves. I guess you know, from your, that’s the qualifications that you have. I don’t know if that’s right?!

Page 11

This participant uses modifiers “particularly” and “probably”, which work to introduce vagueness and tentativeness about her awareness of the standards (Turnbull and Saxton 1997, cited in Wood and Kroger 2000, p.211). The lack of pronoun in “not particularly familiar with it” works to disassociate responsibility for this lack of awareness (Goffman 1981). The frequent use of “you know” conveys uncertainty and this is confirmed by “that’s the qualifications that you have. I don’t know if that’s right?” as the standards are not about qualifications and the question illustrates that the participant does not know what the standards consist of.

Participant 7T

I'm familiar it is there, I wouldn't say I've read any of it very recently probably since I did my DCT ( ) and flicked through (it?). Actually that's a lie 'cos I remember looking to see what the statement was if you think someone is behaving unprofessionally like we were saying before. Whose responsibility, as a registered technician are you responsible as a bystander. You're not allowed to be a bystander, I read that statement to double check. So yes we have been in it recently.

Page 16

This participant did her DCT (pharmacy dispensary checking technician qualification) in 2000, which was some time before the voluntary register opened in 2005 and registered pharmacy technicians were required to abide by the 'Code of Ethics'. However an example of using the standards is then provided followed by "I read that statement to double check" helping to construct this account as factual (Potter 1996b). The change in footing through using the pronoun "we" in place of "I" in the last sentence works to deflect responsibility to be familiar with the standards to an anonymous "we" (Goffman 1981). Participant 8T provides a justification for her lack of awareness of the standards:

Participant 8T

Well again, again, I mean, I was more aware, I was more aware of it and read it when we got it through with our Journal. And I suppose now that you've mentioned it I'm thinking I'll have to go and get another one, because I haven't read it this year, because usually I would read through and just, quite sad, well it isn't sad, I mean.

Page 13

When pharmacy technicians first registered voluntarily with the RPSGB this included a weekly Pharmaceutical Journal and any updates to the 'Code of Ethics' (as it was entitled then) would be sent with the Pharmaceutical

Journal. This ceased to happen in 2011 when pharmacy technician registration with the GPhC became mandatory; the RPSGB became the leadership body for pharmacists only and stopped sending the Pharmaceutical Journal to pharmacy technicians. This participant's discourse illuminates a potential dilemma: first the hesitancy "well, again, again, I mean, I was more aware, I was more aware" in responding before blaming the lack of awareness of the current standards on not being sent a copy with the Pharmaceutical Journal. Then a conscientious pharmacy technician is portrayed through the assertion "because I haven't read it this year, because usually I would read through".

Participant 12T

I know there is one but I've not particularly read it.

Page 14

"I know there is one" suggests that this participant has not read the standards but then the vague and contradictory "but I've not particularly read it" implies that she has at least read some of it. This may be to avoid 'admitting' outright that she has not read the standards.

4.6.3 Discussion

Analysing features of discourse allowed the dilemmatic nature of the responses to be illuminated: pharmacy technicians were not familiar with the 'Standards of conduct, ethics and performance' (General Pharmaceutical Council 2012a) but realised that they should be. Ethical considerations are

said to be the ‘essence’ of professionalism (Beaton 2010). This then begs the question, how can pharmacy technicians undertake ethical-based decision-making if they are not familiar with the GPhC ‘Standards of conduct, ethics and performance’? Further, are there broader aspects to ethical decision-making of which pharmacy technicians require to be knowledgeable?

According to Chaar, Brien and Krass (2005) Codes of Ethics are commonly not used by practitioners so pharmacy technicians are not unusual in this respect. Benson, Cribb and Barber’s (2009) study ‘Understanding pharmacists’ values: a qualitative study of ideals and dilemmas in UK pharmacy practice’ found little evidence of pharmacists applying ethical principles to their decision-making and therefore participants were inclined to make paternalistic decisions based on their moral judgement of what was in the ‘best interests’ of patients. The authors conclude that there is a requirement for improved knowledge of the ‘Code of Ethics’, as it was known at that time, and a need to find “more fundamental mechanisms to build professional structures and cultures which combine greater literacy about values and ethics ...” (Benson, Cribb and Barber 2009, p.2229). Up until the ‘Standards for the initial education and training of pharmacy technicians’ were updated in 2010 (General Pharmaceutical Council 2010a), the syllabus did not contain any reference to regulation, professionalism or ethics. Therefore the vast majority of pharmacy technicians currently practising have had no specific education regarding ethical decision-making.

A study by Gallagher (2011), 'Assessment of levels of moral reasoning in pharmacy students at different stages of the undergraduate curriculum', utilises Kohlberg's theory of moral development to measure the advancement of moral reasoning of students through their four-year training period, with an aim of establishing a causal link with ethics taught at the university involved. The curriculum included various opportunities to discuss ethical dilemmas, the analysis of legal cases and the requirement for students to produce a portfolio of evidence related to ethical decision-making. The author's findings indicated that participants demonstrated "significant moral growth", with the biggest increase taking place in the year most of the ethics teaching took place (Gallagher 2011, p.377-378). However the author urges caution with the findings due to the lack of 'cause and effect' built into the research design. Gallagher's finding is also contrasted with studies into medical and veterinary ethics education, whereby anticipated increases in moral reasoning between first and fourth year of students' education were not found, with the conjecture that this was due to the rigid curriculum for these students.

Middleton's study (2007) 'What do technicians think about registration and professionalism?' also identified a gap in pharmacy technicians' training regarding the 'Code of Ethics' and ethical decision-making.
Interestingly, each of the above studies used 'morals' and 'ethics' interchangeably. Rennie, Nichol and Carmichael (2007) provide a clear definition for these terms: morals are "culturally sensitive rights and wrongs" (p.372), and ethics are "principles to assist decision-making" (p.373). Therefore morals are personal beliefs about what is right and wrong, with

moral decision-making involving the imposition of personal views on to others and which are likely to based on emotion; ethics focus on the rights of the patient and the responsibilities of the professional.

Considering that the GPhC (2012a) demands that all registered pharmacists and pharmacy technicians adhere to the 'Standards of conduct, ethics and performance', and the requirement for all registered pharmacy practitioners to declare adherence to these (General Pharmaceutical Council [no date] c), the gap in pharmacy technicians' knowledge of these standards requires to be addressed. However there are broader requirements as evidenced by the literature: pharmacy technicians need to understand and apply ethical decision-making, and education and training is required to reflect this aspect of professional practice. Eraut (1994) asserts that whilst education, training and assessment can prepare students for ethical practice, qualifications test what people know, they do not test what people do in an ongoing manner, in particular with competency-based training (as is the pharmacy technician entry qualification), and therefore there is a requirement for ongoing monitoring throughout an individual's career. Hence as well as reviewing requirements for changes to the entry level qualification, there is a need to consider how pharmacy technicians can be supported to continue to use the 'Standards of conduct, ethics and performance' (General Pharmaceutical Society 2012a) to aid ethical decision-making.

4.6.4 Summary

Pharmacy technicians are required to adhere to the 'Standards of conduct, ethics and performance' (General Pharmaceutical Council 2012a) and provide an annual declaration that they will do so (General Pharmaceutical Council [no date] c). None of the pharmacy technicians asked was familiar with the standards but their discourse illuminated this as a dilemma for them. As discussed in Section 4.4 on altruism, pharmacy technicians have not had any professional socialisation and ethical practice has only recently been added to the 'Standards for the initial education and training of pharmacy technicians' (General Pharmaceutical Council 2010a). The gap in awareness of these standards needs to be addressed with practising pharmacy technicians, along with a review of initial training and ongoing awareness and monitoring of ethical, not moral, decision-making.

The annual declaration that each registrant of the GPhC must make also includes adherence to standards for CPD, which will be explored in the next section.

4.7 Excellence: Continuing Professional Development

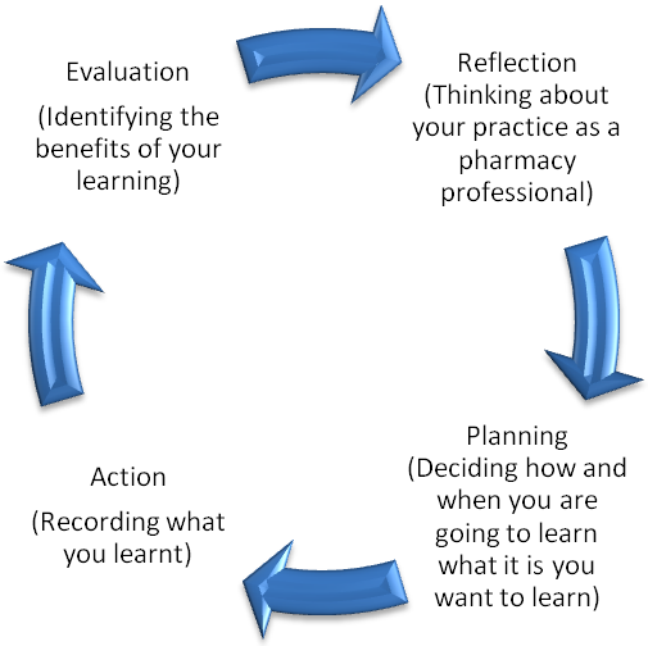
4.7.1 Introduction

The GPhC sets standards for Continuing Professional Development (CPD) that all registered pharmacy professionals must adhere to. The GPhC defines CPD as:

> *... a process of continuing learning and development throughout the life of a professional. It enables pharmacists and pharmacy technicians to develop in their roles and demonstrate that they are competent in their area(s) of practice. It is not just about participating in continuing education, but an ongoing process of reflection, planning, action and evaluation.*
>
> (General Pharmaceutical Council 2013, p.2)

The process of ongoing reflection, planning, action and evaluation is understood as the CPD cycle, illustrated in Figure 4-1.

Figure 4-1 The CPD cycle



(General Pharmaceutical Council 2011c, p.5)

CPD requires professionals to take responsibility for their own learning and development. It is a legal requirement that registered pharmacy professionals must record nine appropriate CPD entries each year, with at least three of these starting with reflective practice (General Pharmaceutical Council

2011a). Reflective practice is acknowledged as a critical component of effective professional development (Moon 2000). Prior to registering with the GPhC pharmacy technicians were under no obligation to perform or record CPD, therefore this was a new concept to many when they registered.

4.7.2 Analysis: CPD

Given that CPD is mandatory for registered pharmacy technicians and that its purpose is to demonstrate competence, pharmacy technicians were asked "what do you think about CPD?"

Participant 1T

Well I joined the portal thing, you know on the website? For the CPD.

Interviewer: The NES one?

Uh huh, and they keep sending me all these emails about courses and things and I think I don't have time for this! So I think, yeah, that's gonna, because we have to do 9 items a year, specific things. I mean we're doing it anyway, we are learning but when you say to somebody you're going to have to record that we're all going to be like, oh no!

Page 4

Participant 4T

As I said before you know we, we are always learning and there is mandatory training that you need to go on. And you know I was always doing it, it is just a case of you know actually formalising it. You know putting it down on paper, now on-line. You were doing it, it's just the time. You don't get time to do it at work it's something you do in your own time to get it logged as a record.

Page 8

Participant 1T's "doing it anyway, we are learning" and Participant 4T's use of extreme case formulations "always learning" and "always doing it" work to

inoculate against any potential criticism over failure to undertake CPD (Potter 1996b). This is followed by a justificatory account by both participants that the problem is recording CPD: "you're going to have to record that we're all going to be like, oh no!" and "just a case of you know actually formalising it. You know putting it down on paper, now on-line". Thus CPD is established as a task, not a system to aid professional development. Both of these participants also gave a further justification - time: "I don't have time for this" and "it's just the time", with Participant 4T going on to shift the blame on to the workplace with "You don't get time to do it at work". However Participant 4T then moved onto a more positive account of CPD related to a sense of achievement, whilst still conceding that recording CPD is the problem:

Participant 4T

Yes I think it's a good thing. Makes you think about it and oh yes I have achieved a lot. Appraisal is the same, you know it helps you with that as well, KSF and that. I don't have a problem with it, apart from getting it logged!
Page 8

Time and lack of protected time at work was also a feature of Participant 6T's account:

Participant 6T

I think it's getting the time as well for CPD and e-KSF. Because we don't get protected time, it just doesn't happen. It's all very well if you are a single person but we are struggling, I'm really struggling, to try and keep on top of it.
Page 4

Again this participant emphasises how difficult it is to meet the standards for CPD using extreme case formulations (Pomerantz 1996) in "we are struggling,

I'm really struggling". Moreover, consistent with the previous participants, CPD is presented as a 'chore'.

Participant 12T also complains about not getting time at work for CPD but adds further criticisms regarding CPD being a "tick box" exercise at present:

Participant 12T

I don't think we get enough. I think we could do more within the work setting, CPD. I mean you are really just told well you've got so much CPD to do and here you go and do it. It's a tick box really and it shouldn't be like that – it should be something you're interested in or something to do with your work or something that will benefit the department that you can do. More like project work you know that kind of thing rather than just go and do 9 sets of reading literature or whatever it is you're going to do just for the sake of ticking a box.

Interviewer: So you find it more like that rather than doing something and then saying oh.

I mean this year I've done, well I've done a few aseptic sort of study days and I've done my DCT so that kind of ticks all the boxes for me for my CPD. But you know if you were just going along to something or reading something for the sake of ticking a box I don't see the benefit in that, it needs to be more relevant and like project work we need to maybe be given something. And I suppose I have done project work in the fact that I've set up a you know, I've looked into how we could run this service and that's a project reporting back. But I think something more like that for the technicians that would involve them in the running of the department rather than ticking a box saying I've read that even although it's got no relevance whatsoever to what they do.

Page 6-7

The lack of agency applied through "you are really just told well you've got so much CPD to do and here you go and do it" conveys a lack of control and ownership of doing and recording CPD (Goffman 1981). The notion of 'box-ticking' is prominent, this metaphor painting a picture of CPD being a useless exercise. The need to make CPD more relevant is affirmed through a three-part list of criticisms regarding the situation: "it should be something you're

interested in or something to do with your work or something that will benefit the department that you can do". Three part lists work as powerful rhetoric, making accounts more credible and authentic (Jefferson 1991). For her CPD this participant used study days and completion of the dispensary checking qualification to 'tick the boxes', so making reference to continuing education rather than any other form of CPD. Lastly, this participant's remark that "it needs to be more relevant and like project work we need to maybe be given something" implies a passive position and a lack of understanding or ownership of CPD.

Participant 8T also provides a negative account of CPD:

Participant 8T

It's a nightmare, I hate it.

Interviewer: Oh do you?

Well, I know it's got to be done, I know it's easy to do and I was the one with (name removed for anonymity) that went to (name removed for anonymity) to hear all about it and come back here, had heaps of seminars about it. We'll get it done, we'll get it done.

Page 8

The extreme case formulations "it's a nightmare, I hate it" work as powerful rhetoric to emphasise this negative account of CPD (Pomerantz 1986), but this is followed by the concessions "I know it's got to be done, I know it's easy to do" and then an account of her knowledge about CPD through hearing "all about it" and having "heaps of seminars". This conveys that her dislike of CPD is not down to a lack of knowledge or understanding. The change of pronoun use to "we'll get it done, we'll get it done" could be working to deflect

from her own lack of achievement but could also be a signifier of a dilemma as the participant knows CPD is mandatory requirement.

Participant 7T gave the most favourable account of CPD and, similar to Participant 4T, presents CPD as enabling a sense of achievement in the following two excerpts:

Participant 7T

I think it is quite good because once you have recorded something and then you use it you actually, it makes you think I have learned something from it ... And I think it is easier for other folk to tell you things you have learnt or done well, rather than you doing it yourself. Folk find it really hard to write in their CPD, bigging themselves up really.

Interviewer: I know I think it is the Scottish mentality as well isn't it we are really bad at that

It's part of the culture, ( ) it's culture but no I quite like to write in my CPD. I have never had it audited, but I don't know if I'm doing it properly or not, but we have had training nights through NES. I use it myself to see what I have learnt.

Page 7

Using repetition Participant 7T emphasises that she uses CPD to see what she has learnt and is the only participant that talks about carrying out reflective practice, the critical component of CPD (Moon 2000). Her description of people finding it hard to write their CPD because it is "bigging themselves up really" may illustrate that pharmacy technicians are modest in their achievements but also illustrates a lack of understanding of the purpose of CPD.

4.7.3 Discussion

The interviews for this study were carried out shortly after mandatory registration and therefore CPD was mandatory for pharmacy technicians at that time. Although pharmacy technicians who registered prior to mandatory registration in 2011 under the voluntary registration and grand-parenting periods would have had experience of CPD, it was still a relatively new concept for pharmacy technicians at the time of the interviews. This should be borne in mind when analysing the interview transcripts, although a systematic review carried out by Donyai et al. (2011) on pharmacists' views on CPD, who have had to comply with CPD requirements since 2005, found similar barriers to those established in the present study in relation to a lack of time for CPD, a lack of understanding of CPD and attitudes towards CPD.

Reflexivity is a critical component of effective professional development (Moon 2000) but only Participant 7T talked about CPD in terms of reflective practice. This apparent lack of awareness or understanding about using reflective practice for CPD was also a finding in a recent study by Schafheutle et al. (2012) into pharmacy technicians' views of learning and practice implementation including recording learning as CPD.

Other than Participant 7T and Participant 4T who spoke about a sense of achievement, accounts about CPD were negative and there was a lack of value attributed to CPD. The notion of 'always learning anyway' was common and it was the external factors of needing to record CPD and a lack of time to

do that which were identified as issues. A lack of time, including a lack of time given at work, is in common with other studies carried out on CPD and the pharmacy professions (Donyai et al. 2011; Schafheutle et al. 2012).

Learning was equated with going on courses or gaining a qualification and therefore CPD is confused with continuing education. The description of CPD as a 'tick box' exercise undermines the value of CPD. The GPhC in their first registrant bulletin states "CPD is not a tick-box exercise: it plays a key role in enabling registrants to reflect on and apply their learning, and helps to bring into focus everything you learn as you go about your work as a pharmacy professional" (General Pharmaceutical Council 2011b, p.16).

Whilst the GPhC has produced CPD standards (2010b), a CPD framework (2011a), guidance for planning and recording CPD (2011c) and CPD frequently asked questions (2013), the issue regarding a lack of understanding of reflective practice has not been addressed. The lack of reflective practice and general negativity about CPD amongst pharmacy technicians may be attributed to a number of reasons. First, pharmacy technicians' current entry level qualification does not prepare them for reflective practice. Second, considering that pharmacy technicians' development is often dictated to them by their employers e.g. mandatory training in the workplace or the need to undertake the dispensary checking technician qualification to get promotion, it removes the need to identify their own learning needs. Third, NHS Education Scotland's pharmacy directorate delivers a range of CPD evenings for pharmacy technicians. Whilst pharmacy

technicians may have identified the topic of the CPD evening as a learning need, my experience is that pharmacy technicians attend these to add to their CPD record and not necessarily in relation to an individual learning need they had previously identified.

Knowles (1984) in his theory of andragogy claims that adult learners need to understand how learning will be of benefit to them before they can value the need for it. Therefore if pharmacy technicians understood the benefit of reflective practice, both in terms of their practice and what they have learned (the reflection and evaluation stages of the CPD cycle), they would be more likely to carry out CPD in a manner that meets the requirements of the regulator and actually supports professional development.

4.7.4 Summary

Pharmacy technicians must record nine CPD entries each year (General Pharmaceutical Council 2011a) and reflective practice is recognised as a critical component of effective CPD (Moon 2000). Within the interviews a number of interpretative repertoires, that is, ways of speaking about a topic (Potter and Wetherell 1987), were at play regarding CPD. First, CPD as a recording/formalising exercise because people are “always learning” and “doing it anyway”, just not recording it. Second, CPD as a box-ticking exercise, thus it has no value. Third, CPD would be done if only there was time. Fourth, a passive notion of CPD in that pharmacy technicians need to be

given projects and given time at work to do it. Lastly CPD is presented as a way to promote a sense of achievement.

Whilst it should be noted that the interviews were carried out in the first year after mandatory registration in July 2011, there would be benefits in raising pharmacy technicians' awareness and understanding of the purpose of CPD and the notion of reflective practice in particular.

Whilst CPD requires individuals to take responsibility for their own learning and development, the next section explores advancing practice of the pharmacy technician profession.

4.8 Excellence: Advancing Practice

4.8.1 Introduction

In the sociology of the professions, according to the power approach, professions take responsibility for the advancement of their practice (e.g. Larson 1977; Witz 1992). Whilst pharmacy technicians' roles have advanced considerably in the last 20 years, it is questionable how much of this was driven by pharmacy technicians themselves or instead occurred as pharmacists 'rid' themselves of tasks that they considered pharmacy technicians had the knowledge and skills to do.

As previously discussed, ‘Prescription for Excellence’ (Scottish Government 2013a), the strategy for pharmacy in Scotland, and ‘Now or Never’ (Royal Pharmaceutical Society 2013), its English equivalent, demand better utilisation of pharmacy technicians’ skills which therefore involves further role development. Regulation may be considered to provide a governance framework for role development of pharmacy technicians given that regulation sets a standard for education and training, commits registrants to ethical practice and accountability for their own practice with the prospect of sanctions if the ‘Standards of conduct, ethics and performance’ are not met. A presentation at an ‘Optimising Pharmacy Skill Mix’ workshop (Great Britain. Department of Health 2014) recognises that skill mix optimisation is enabled by pharmacy technicians being part of a regulated profession.

4.8.2 Analysis: Advancing Practice

This section starts with the Directors’ of Pharmacy responses to a question asking why pharmacy technicians’ roles have changed up until now. Next, participants were asked if they thought that pharmacy technician roles could be further developed and lastly they were asked if regulation would aid role development.

Participant 1D

So I think there’s been two things, but I don’t think they’re complimentary things. One, a desire by technicians to advance their practice and two, a recognition from pharmacists that technicians have those skills and abilities and actually some leadership from some very good pharmacists who have actually said no, this, this is stuff that you should be doing, but you couldn’t

have done it unless the pharmacists, senior pharmacists supported it. So I think that's happened. The increasing complexity of care so it's basically recognising the changes in medicines and so forth, so effectively pharmacists have had to divest themselves of some of their roles to take on the other things they're needed to do and so they automatically look to technicians to take on those roles for them.

Page 17

Whilst acknowledging that pharmacy technicians had the desire to advance their practice, the real reason that pharmacy technicians' roles have advanced was leadership from "some very good pharmacists". Further, we "couldn't have done it unless the pharmacists, senior pharmacists, supported it". This is explained by pharmacists' roles developing and therefore they "have had to divest themselves of some of their roles ... so they automatically look to technicians to take these roles on for them". There is no mention of leadership by pharmacy technicians, who are instead portrayed as acquiescent, taking on roles as decided upon by pharmacists. The other Director of Pharmacy also assigned responsibility of pharmacy technicians' role development to pharmacists in the following two excerpts:

Participant 2D

I think there's a bit of necessity in terms of, I think of the role of the technician, if I look at it in secondary care, there has been a large element driven by what the pharmacist wanted to do or would have liked to have done.

Page 34

So I think it's been a, I would love to be able to say to you that I think it's been the technicians collectively grabbing the bull by the horns and changing their roles, but I don't think it's been it to that point, up to now. But I think with the registration in 2011 I think there is a step change there. Naturally there's got to be a step change.

Page 35

Again the development of pharmacy technicians' roles is attributed to the need to develop pharmacists' roles. This Director uses a politeness strategy

in “I would love to be able to say to you that I think it’s been the technicians collectively grabbing the bull by the horns and changing their roles, but I don’t think it’s been it to that point, up to now”. Brown and Levinson (1987, cited in Wood and Kroger 2000, p.48) define politeness strategies as devices used when the speaker is concerned with accomplishing a criticism (in this case) whilst ‘saving face’ of pharmacy technicians. Registration is then acknowledged as the catalyst for a “step change”.

In response to a question about the future role development of pharmacy technicians participants described a ward-based role. This is not surprising given that most hospital pharmacy services have moved to pharmacy technician-led department-based services e.g. dispensary, distribution and procurement, and some hospitals have already developed the ward-based pharmacy technician role. Two discourses emerged regarding this ward-based role: the need for ‘accredited’ training and the individualistic nature of this role development at present.

Participant 1T

Yeah. I think even, especially on the ward like taking patient medication histories, and even phoning the GPs to get the patient medication history and things. I think there’s a girl at the [location removed to protect anonymity] she’s going to start to do that, inhaler techniques, counselling and more than capable to do it. I know some do do it, it would all go down to the individual - some people aren’t comfortable with that sort of thing, but with the right training and things, I think technicians are capable of doing all these.

Page 14

Here the notion that “some people aren’t comfortable with that sort of thing” is provided as a justification for it being “down to the individual”. However this

claim is then qualified with “but with the right training ... technicians are capable of doing all these”. Participant 12T also identifies training courses as the answer to support role development:

Participant 12T

Yeah I’m sure, I’m sure there’s always room for development. We don’t have clinical technicians here, I think that’s something that will develop.

Interviewer: Right, ok so that might be the next step here. What do you think would help for the roles to develop in the future?

Well there are courses now - there’s a new course connected with our DCT and it will run with the DCT course next year. I was probably the last one to start the old course ... There’s a clinical, I don’t know if it’s called clinical DCT but the DCT at the moment is two modules but the next one will be four, and it’ll have the checking with the clinical role attached. They’ll be running it from next year. Before ( ) they want all our DCTs to go and do this clinical add on bit that you can do if you’re already DCT. And it’s got SVQ approval.

Page 14-15

The corroboration “And it’s got SVQ [sic] approval” at the end of this excerpt works to bolster the claim; approval makes this qualification desirable and worthy. Participant 4T also identifies the need for ‘formal’ training for working on the wards:

Participant 4T

I think there is a lot more that could be done you know on wards, and you know speaking from our own, we have only just sort of dipped our toe into the water on the wards, medication histories - I think they do that in bigger hospitals and go and do you know the job that they have to do. There must be a lot more that could be done.

Interviewer: So why do you think that’s not happening at the moment then?

I don’t know. Obviously there would be training required whether that... you know there is nothing formal, a lot of it is being done in house and I guess it depends on the pharmacist, you know, whether they, I mean not to be negative but with all the staffing problems that there are, we, you know we are

pulled back to the department an awful lot you know just to get the medicines out the door point of view.

Page 14

Here the barriers to role development start with the “obvious” need for training leaving that requirement in no doubt. Then in-house training is identified as a further barrier because “there is nothing formal” implying that formal training would be an improvement. Then matters outwith pharmacy technicians’ control appear to impede role development. First, “I guess it depends on the pharmacist”, whilst not being clear which pharmacist this refers to i.e. dispensary pharmacist or clinical pharmacist, it portrays the pharmacist as the decision-maker in organising staffing. Second “we are pulled back to the department an awful lot just to get the medicines out the door ...”. Extreme case formulations “awful lot” and “just to get the medicines ...” work in the first case to emphasise the frequency of this occurrence, and in the latter example to illustrate that this is to do the ‘basics’ (Pomerantz 1986). Herrera (2010) in her doctoral thesis ‘Evaluation of a Foundation degree for pharmacy technicians’ also found this focus on traditional supply chain functions a barrier to role development. The need for formal training is alluded to in Participant 7T’s response as the developed role is undertaken by “one with a clinical diploma”:

Participant 7T

Here I think yes. ( ) more out on the wards, we have only got one with a clinical diploma that really chases into the nitty gritty of your previous drug history when you come into hospital. The rest of the techs out on the wards are mostly all band 4s doing one-stop supply, which we call medicines management, and I think there’s folk out there that do a lot more of that.

Page 17

Next the pharmacists' accounts, commencing with Participant 5P:

Participant 5P

I guess, more clinical - we're not covering every ward. I think if we could get to a level where you had that then could look at Ok can they now do more. Loads more technicians could be involved in ( ) to be honest.

Interviewer: Why do you think it doesn't happen at the moment then or what do you think needs to.

Some technicians are really good at the moment. I would say it's very much about where is it good to go and where are we allowed to go. I think with pharmacy technicians wanting to go and.

Interviewer: Does it tend to be things they are trained to do then that they will do that.

A technician before them has told them, you know, this is what I do, this is my daily role and all the rest of it. They are probably less likely to do it if the person before them hasn't done it because they think well they didn't do it, why am I doing it? Am I meant to be doing it?

Page 9-10

When asked why more technicians were not on the wards this pharmacist answered "some technicians are really good at the moment". This implies that not all pharmacy technicians are really good and therefore the lack of progress with developing the ward role is down to this. However she can be seen to qualify this with "where are we allowed to go" although the granter of the permission is not specified. Lastly a sense of confusion is portrayed over the actual role of the pharmacy technician on the ward in "am I meant to be doing that?" illustrating a lack of a planned approach to this development and a lack of clarity over the role.

The next pharmacist also makes reference to there being scope for pharmacy technicians working on the wards, but that there is a need for training: that

currently these roles have developed due to individual pharmacy technician's capability rather than a planned service-wide approach.

Participant 10P

I mean I think there's a lot more that technicians, I mean that technicians are starting to kind of, you know, in terms of wards, starting to work more clinically, I think there's a lot that technicians could, could do.

Interviewer: What would enable that?

Oh, I suppose, you know, well, you know first training, you know, would be required in terms of, I'm thinking specifically around you know patient counselling, medicine reconciliation, which I know is happening in some areas but it's not wide-spread and it's still, it's still quite early days and there's pockets of good practice but again it's, that's down to individual technicians and capability and you know, staff that have been allowed to develop rather than a, a service wide initiative to actually change delivery of service.

Interviewer: What do you think would enable that to happen then, to get to that stage where that is common, that technicians do medicines reconciliation and patient counselling?

I mean, there would need a, needs to come, it needs to be a drive, you know, to do it via, sort of Directors of Pharmacy, through NES, you know through, you know, accredited training because that's when staff get, you know, staff actually get the recognition to, you know that they have the skills to do this.

Page 15

The need for leadership at a national level through the Directors of Pharmacy is pointed out along with the need for "accredited training" because that's when "staff actually get the recognition ... that they have the skills to do this". Thus there is a lack of accountability to make these changes happen at a local level and direction from 'above' is required. Again there is the notion of pharmacy technicians requiring certification of competence so that others have confidence in their abilities.

The next question centred on regulation supporting, or not, role development.

Participant 12T

I'd like to think it would considering we're paying our fees. It should.

Page 15

Participant 12T connects paying fees with supporting role development, implying that being part of a registered profession brings with it benefits of role development. The next participant also gives a favourable response to regulation supporting role development:

Participant 8T

I would hope it would support it, in as much that there are standards we have to meet as opposed to just getting through your qualification. And then we've now got to say, and obviously somebody's got to sign off to say, that this person is, is competent and I, I would hope that it would help to push for a better standard.

Page 13

The notion of meeting standards and the fact that being registered signals competence are identified as drivers for role development. However not all participants agree that regulation supports role development:

Participant 10P

If we had the staff we would have it developed anyway.

Interviewer: but does it matter that they are registered?

To be honest I don't, I don't think so. 'Cos you look at, you know, other Trusts and others services throughout the UK, you know, they've developed in different ways, you know. As I say technician-led services being developed, everyone picks up other models and who's done what and tries to adapt it to their own.

Interviewer: I just wondered with some of the reticence in some areas there seems to be, you know, the risks associated with technicians taking on those roles and by putting regulation in that would provide that kind of security I suppose?

Yes I mean it's worth, certainly being regulated means they are professionally accountable which I think is the, is the biggy. I think for technicians themselves that's a big thing, you know, that you are now professionally accountability for what you do.

Page 16

Participant 10P continues with her previous assertion that a lack of staff has hindered role development and then gives examples of how other areas have developed roles prior to the regulation of pharmacy technicians. This is preceded by "to be honest" which conveys a notion that the speaker expects that what follows may not be well received (Edwards and Fasulo 2006, cited in Tseronis 2011, p.482), however the way the question was framed in the interview may have contributed to that. Participant 4T also considers regulation unimportant in the development of pharmacy technicians' roles:

Participant 4T

You know I have been here for 23 years myself and I don't know that it will.

Page 14

Using a time reference in "23 years" works to create authenticity for the remark "I don't know that it will" (Widdicombe and Wooffitt 1990). Participant 9P gave a different account, starting with a concern that regulation may in fact stifle innovation:

Participant 9P

I would hope that regulation wouldn't stifle that, that regulation wouldn't stifle creativity that people have of developing the role … The, our role has developed so much without really radically changing the Code of Ethics, really changing the way that we are expected to behave and are expected to operate. So I think as long as the regulations don't stifle that creativity of people to expand the role, develop into areas where, you know, we are doing the best that we can for the patient group that we've got.

More narrative then:

Interviewer: I just wonder as well if, if regulation will give, you know I'm thinking of areas that maybe haven't developed the technician role as well if it will give them kind of, you know they've got that kind of, you know, kind of support for developed roles?

Yeah. You've got the sort of clinical governance really; you've got a much tighter, tighter regulations really for working as a professional rather than somebody that's not regulated.

Page 14-15

Here the concern regarding regulation appears to be explained by this participant's experience as a pharmacist but when prompted to consider pharmacy technician roles, the speaker then identifies that regulation does provide a "sort of clinical governance" and provides tighter regulations than someone not regulated. Participant 2D, a Director of Pharmacy, reiterated that regulation supports role development:

Participant 2D

I think from a, a leadership and strategic perspective it allows us to start to, really think about how we can use the technicians in our service differently to, to redesign services with the under pinning, you know, regulation and that professionalism that, that registration brings.

Page 1

The category entitlement "from a leadership and strategic perspective" gives authority to the claim that follows (Potter 1996b), that redesign is enabled because regulation brings with it professionalism. However this Director then describes barriers to role development:

Participant 2D

I've been pushing the previous Director of Pharmacy as accountable officer just to allow the pharmacy technicians, ward based technicians, to do CD

checks ... and it was approved and we put the training in, and the competency framework in and so on but really frightened of it almost, the technicians.

Interviewer: Yeah because that's a pharmacist job, we don't do that

Yeah, yeah. And the confidence is just not there.

Page 25

Here, extreme case formulation "really frightened" and "confidence just not there" emphasise the suggested concerns that pharmacy technicians lack confidence to develop their roles (Pomerantz 1986). The following account presents a positive view of work done in this Health Board to develop the pharmacy technician role but that this is thwarted by pharmacy technicians' lack of confidence:

Participant 2D

We've got issues around patient flow, and beds, and you know, and, and how do we, so where does the technician role, what's the unique contribution in that? OK what skills are, are, what educational gaps are there? How do we map that in and then let's, you know, but when I speak to the technicians about you know, some of the lack of confidence, some of the testing we've done with some of the different models, the first thing that usually comes back is, "I, I, just feel this is not supported by a formal qualification".

Page 26

The use of reported speech "I, I just feel this is not supported by a formal qualification" warrants facticity and works to make a strong claim for the lack of formal qualifications available to support advanced roles for pharmacy technicians (Potter 1996b). The reported speech also assigns responsibility for this 'view' onto pharmacy technicians. In addition, this Director proposes how pharmacy technicians could be involved in role development in the future:

Participant 2D

And I think we're seeing that and I think that we, I think that some of the things we've talked about in terms of that leadership and so on, if that's there then I think that that will be the differential between where we've been, in terms of always being done to, to actually saying no, this is where we add the most value and it has a, you know, almost the technician profession has an equal voice around the table about service redesign. You know, and, and being able to put their hands up and say OK guys that, that would be great that you would like us to do that, but actually that's going to take four years for us to get there because we need this education to go in.

Page 35

Whilst this account is on the face of it positive in supporting pharmacy technicians to be involved in the development of their roles, there are two features that portray pharmacists as the 'dominant' profession. First, the use of 'almost' in "almost the technician profession has an equal voice around the table...", so pharmacy technicians are placed in a subservient position. Second, in the sentence "... Ok guys that would be great that you would like us to do that", it is still pharmacists that are suggesting the role changes rather than being driven by pharmacy technicians. This participant goes on to say:

Participant 2D

But I think it's, how do we, how do we really plan to set them up for success as a profession, rather than OK we've got this good idea and it's been driven by whatever, patient flow and other things, OK, so next month we require you to start doing this or testing this, and it just feels like it's a bit reactive.

Page 36

Whilst this account offers a keenness to develop pharmacy technicians as a profession, pronouns "we" and "them" along with "we require you to start doing this" again portrays pharmacy technicians as being 'done to'. However the other Director of Pharmacy gave an alternative account:

Participant 1D

No, I mean, and that's, that's where you've got to start working as a professional, you need to decide whether there's things that you think would be appropriate for technicians to do and then present the case for that, and get others to argue for that case.

More narrative then
So, so, that's, but I actually think that there's, there is a massive pressure coming and that that will drive things quickly. And, you do need to be prepared for it as a professional group because you may end up getting the tasks that people don't want. As opposed to the tasks you think you're best suited for, so that's what you need to think about.

Page 17-18

Here, the pronoun use of "you" and the instructions "you've got to start working as a professional" and "you do need to be prepared for it as a professional group" put the onus very much on the pharmacy technician profession to take responsibility for its own role development.

In relation to pharmacists' acceptance of pharmacy technicians' developing role, the Directors of Pharmacy both highlighted previous tensions with pharmacists but that workload pressures were changing that:

Participant 2D

Again I mean I think in secondary care they're, they're, they're desperate for, to, the pharmacists on the whole, on the whole, to perhaps speed up, you know, they're always, because they, they're recognising the pressures that they are under and where they would like to do more in terms of prescribing and embed that into their practice and, you know, be, be more integrated into the multidisciplinary team but there's things that are pulling them back from that because of other roles that they are doing, where they might feel that if I was better supported by technicians then I could deliver some of that.

Page 37

The description of pharmacists being "better supported by technicians" in order to meet their own role development, whilst describing an acceptance of

pharmacy technicians developing roles, also continues to place pharmacy technicians as the subordinate occupational group, supporting the pharmacist. This notion of 'helping' is also seen in the other Director's account:

Participant 1D

And, and, and there has been I think in the past, there's been a bit of a tension around that, there's been a bit of a tension. I don't sense it at the moment at all to be perfectly honest, and one of the reasons I don't sense it is because I think everybody knows there's too much work for everybody to do. Whereas in the past there was, and you'll be aware of this I kind of think, "this is not a technician's job, why do they think, this is our job, we're pharmacists", type thing. Now I think everyone, the pharmacists are going we've got far too much work to do if anybody else is going to help us, thank you. And that's good.

Page 18

The past tensions are ascribed to pharmacists protecting their roles and displays of 'professional arrogance' with "this is not a technician's job" and "we're pharmacists". This reported speech distances the Director from that viewpoint (Potter 1996b). Now however, because pharmacists now have too much work to do, the door is open for pharmacy technicians to "help" them. Participant 2D remarks that there are still some pharmacists resistant to pharmacy technicians' advancing practice:

Participant 2D

I still think there's a small component of a small element of that pharmacist workforce who, I don't know how to describe it. Maybe it's a lack of confidence in, in what the technicians can deliver, lack of understanding probably attached to that, you know about what their qualifications are and, and their experience and training and post qualification training. There's some element of "that's the pharmacist's job", so I think that very traditional view and, and that's where, you know, the, the leadership needs to come in, as professions, you know, and the Directors of Pharmacy and other leaders, you know, to be clear on, on this is the vision, this is where we want to be, and so that

everyone is aspiring to that and then I think if that's there, yes we're always going to have the laggards if you like.

Page 37

Here, the Director uses a minimisation device (Pomerantz 1986) in "there's a small component of a small element of that pharmacist workforce" followed by a disclaimer (Hewitt and Stokes 1975) "I don't know how to describe it" to convey a minimum commitment to the forthcoming potentially controversial claim that "maybe" there is a lack of confidence in pharmacy technicians abilities. The justification for this lack of confidence is a lack of understanding of pharmacy technicians' training and experience but also that "traditional view" that the roles belong to pharmacists. The need for leadership and a vision to address this is highlighted. The next excerpt goes on to reaffirm that there are fewer tensions with pharmacists' roles and how this can be further supported:

Participant 2D

And going back to what we were saying about the professional element of the, the, the jobs I mean, you know, being clear on what the actual responsibilities are, because I think there's still that, the traditional view of the pharmacist is, and this is true to a certain extent of, "I am ultimately accountable", you know, and we saw it, I mean we saw it I suppose in its simplest form in DCTs when they came in. You know, pharmacists "I'm OK I can do this, I don't need, you know, because I'm ultimately accountable for that". But I think that's changed, and that's about, as you say it's about how we deliver the training and the making sure that we provide confidence to everyone in the system that, that, that actually the training is robust and the competency assessment is robust and there's controls there to cope with that.

Page 38

Again reported speech (Potter 1996b) assigns responsibility for the "traditional" viewpoint of "I'm ultimately accountable for that" onto generic pharmacists and a reluctance to relinquish roles because of questions over

accountability. Extremisation (Pomerantz 1986) is used to emphasise the need to "provide confidence to everyone in the system" around training, competency and controls.

Lastly, Participant 1D uses the nursing profession as an example for pharmacy technicians to learn from:

Participant 1D

Nurses are lost a bit. So now they do an awful lot of taking temps, doing charts and this kind of thing, but they, they, they have no time to sit and talk. Caring and talking, and actually what I consider to be nursing care, where is that? And actually they haven't fought hard enough to keep that because, 'cos that hasn't been valued, it hasn't been valued in remuneration terms, it hasn't been valued in, but that's just because, just because society got it wrong doesn't mean they were wrong, they were right. And so I think technicians just need to be very, very careful about not losing what it is that you do well.

Page 15

This description warrants to give pharmacy technicians a warning: nurses are at fault for not holding on to what Participant 1D considers fundamental aspects of nursing and as a result of this they have "lost their way a bit". Extreme case formulations "awful lot", "no time to sit and talk" and "very, very careful" further emphasise the warning about "not losing what it is that you do well" (Pomerantz 1986). There then follows a criticism over specialist roles:

Participant 1D

And also it's interesting in terms of the whole kind of specialist nurse role which is actually now being questioned quite a lot at a management level. So that's questions about actually these people almost like going off and doing whatever they want in their specialist area but actually they're getting paid very high grades. There's, there's a lot of talk about whether in fact that's, that's what the organisation wants. So, actually, and, there's no, there's an absolute recognition that these individuals are good but actually it's almost like well, OK, we have these little people going off, but we've got loads and loads of specialist nurses now, who don't work, work across the piece, who

we can't actually use as a flexible workforce in any way whatsoever, who are incredibly highly paid but they only see a very, very small, select group who get this incredibly good care but then the rest of the people don't get any care whatsoever. So technicians need to be very wary about going for this specialism, which again is very good for people who are individually driven. And it may, it may benefit the individual but will it benefit your growth as a profession?

Page 16

This critical account of specialist nurses describes them as self-interested and an inflexible, "incredibly highly paid" workforce that only sees "a very, very small select group who get this incredibly good care but then the rest of the people don't get any care whatsoever". The extremisation and minimisation (Pomerantz 1986) used together in this excerpt accentuate the criticisms placed on specialist nurses. A three-part concession: proposition (initial criticism over specialist nurse roles) followed by a concession "there's an absolute recognition that these individuals are good" followed by a reprise (more criticism), works to make the offensive rhetoric more powerful (Antaki and Wetherell 1999). Finally, the warning to pharmacy technicians not to go down the self-interested specialism route is repeated.

4.8.3 Discussion

Both Directors of Pharmacy acknowledged that up until now, pharmacy technicians' roles had developed out of necessity through the leadership of pharmacists to free themselves to carry out more advanced roles. Participants described the future role of pharmacy technicians as one that was ward-based, carrying out activities such as taking an accurate medication history and counselling patients on their medicines. Whilst these roles were

presently undertaken, this was small scale and reportedly dependent on the individual knowledge and skills of certain pharmacy technicians. Barriers identified to this ward role being wide-spread included: the lack of formal accredited training; a lack of confidence amongst and about pharmacy technicians carrying out advanced roles; and, a lack of a planned approach to develop and sustain these roles, and as a result pharmacy technicians are "pulled back to the department an awful lot you know just to get the medicines out of the door point of view" (Participant 4T).

Regarding the future approach to developing pharmacy technicians' roles, Participant 1D asserted that pharmacy technicians have " ... got to start working as a professional, you need to decide whether there's things that you think would be appropriate for technicians to do and then present the case for that ...". The other Director of Pharmacy presented an account that on the one hand presented a supportive notion of developing pharmacy technicians' practice but at the same time discursive features such as modality (pharmacy technicians "almost" have an equal voice) and pronoun use (e.g. "how do we .... set them up for success") illuminate pharmacy technicians as passive with pharmacists as their leaders in role development.

The aims of the APTUK, the professional leadership body for pharmacy technicians, includes "to maintain, safeguard and enhance the professional and educational standards of all pharmacy technicians" and "advising the Pharmacy Regulator of how technicians can be put to better use" (Association of Pharmacy Technicians UK [no date] b). In a position statement about

pharmacy technicians supplying medicines through a Patient Group Directive (PGD), the APTUK outlined their approach to developing new roles for pharmacy technicians as being “underpinned by three important principles: protecting patients, protecting pharmacy technicians and maximising the competence of pharmacy technicians alongside their relatively newly registered status” (Association of Pharmacy Technicians UK 2013a, p.1). To do this, the APTUK considers that a rigorous risk-management approach is required for any new role. This requirement for a risk-management approach to role development was also purported in a separate statement about supervision and pharmacy technicians: the President of the APTUK reported that the APTUK supports greater delegation to pharmacy technicians now they are a registered profession, but that there is a requirement for robust risk assessment both by those delegating tasks to pharmacy technicians, and also for pharmacy technicians themselves in relation to their limits and accountabilities (Association of Pharmacy Technicians UK 2011). The president points out that a critical element of the risk management strategy is that pharmacy technicians have the necessary level of competence to carry out new roles and that there are “robust and fully implemented Standard Operating Procedures in place” (Association of Pharmacy Technicians 2011, p.2).

Whilst the reasons behind the requirement for a risk management approach to undertake new roles in the interests of patient safety and to protect pharmacy technicians is understandable, the terminology used by the APTUK does not accord with the definitions of a profession in the sociology of the professions.

First, new tasks will be ‘delegated’ to pharmacy technicians rather than being led by the profession as recommended by one Director of Pharmacy and in accordance with the core requirements of a profession in the power approach (Larson 1977; Witz 1992). Second, the need for robust and fully implemented Standard Operating Procedures (SOPs) implies that all roles for pharmacy technicians must be standardised and require no professional judgement. The GPhC purported a different approach to the APTUK in a presentation at an ‘Optimising Pharmacy Skill Mix’ workshop where Duncan Rudkin, the Chief Executive and Registrar of the GPhC outlined their approach to pharmacy skill mix (Great Britain. Department of Health 2014). Here, patient-centred professionalism is depicted as a balance between a list of permitted and reserved tasks and an exclusive reliance on individual professionalism to provide the ideal position for patient-centred professionalism, affording public assurance and enabling innovation.

Looking outside of pharmacy, nursing is another profession where roles have extended over the years, taking on activities previously carried out by doctors. In 1992, the UKCC published ‘The Scope of Professional Practice’ (United Kingdom Central Council for Nursing, Midwifery and Health Visiting). According to Savage and Moore (2004), this document was a critical component of the professionalisation of nurses as it provided them with the authority to develop their own roles. Prior to this nursing practice was “shaped by acceptance of extended roles by doctors in which nurses competence was assured by certification” (Savage and Moore 2004, p.9). Comparisons can be drawn here with the current situation for pharmacy

technician role development. 'The Scope of Professional Practice' (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1992) made a number of points that are relevant to pharmacy technicians. First it recognised that the nurses' entry level qualification prepared them to practise at a "certain level and encompass a particular range of activities" and that "any widening of that range and enhancements of the nurse's practice requires 'official' extension of that role by certification" (p.8). This is currently the case for pharmacy technicians and one perpetuated in accounts from participants in this study. Second, that the term 'extended role' actually limited practice development due to the need for certification, and this prevented nurses from fulfilling their potential. Third, that "in order to bring into proper focus the professional responsibility and consequent accountability of individual practitioners, it is the Council's principles for practice rather than certificates for tasks which should form the basis for adjustments to the scope of practice" (p.9). Lastly, that these changes are based on the nurses 'Code of Professional Conduct'; of particular relevance here is the requirement that "you are personally accountable for your practice" (p.5) and that practice is focused on meeting patients' needs and as a result nurses must "endeavour always to achieve, maintain and develop knowledge, skills and competence to respond to those needs and interests" (p.6). This does not mean that further education or certification is never required for 'extended' roles, rather that this is not assumed to be the case.

The dental profession has also produced a 'Scope of Practice' (General Dental Council 2013) but rather than this being principle-based as the nurses'

‘Scope of Professional Practice’, it lists the skills and abilities that each of the dental professions should have and also those that can be developed but which require additional training. Further, that training and assessment by an approved training provider is required for more complex skills. This type of codifying helps to clarify roles and accountabilities, and may help improve confidence in practitioners’ abilities but it may also stifle innovation.

The nursing ‘Scope of Professional Practice’ seems to fit with the account of the Director of Pharmacy who said “that’s where you’ve got to start working as a professional, you need to decide whether there’s things that you think would be appropriate for technicians to do and then present the case for that ...” and also with the GPhC’s Chief Executive’s assertion that patient-centred professionalism requires a balance between a list of preserved and reserved tasks and an exclusive reliance on individual professionalism (Great Britain. Department of Health 2014). A ‘Scope of Professional Practice’ would potentially aid role development and clarify accountabilities, although the legal position regarding pharmacist supervision under the Medicines Act (1968) and the Health Act (2006) would need to be clarified.

Whilst the requirement for changes to the current pharmacy technician entry level qualification is discussed more fully in Section 4.3, a Specialised Body of Knowledge, a further consideration regarding the development of a ‘Scope of Professional Practice for Pharmacy Technicians’ is the current foundation level training and whether this adequately prepares pharmacy technicians for professional practice. Herrera (2010) in her study to evaluate foundation

degrees for pharmacy technicians claims that foundation degrees prepare pharmacy technicians for independent roles and increases their desire to advance their practice, although Herrera acknowledges that further research is required to fully explore this aspect of degree level qualifications.

In addition to changes to the entry level qualification, consideration should to be given to developing and supporting a structured career pathway for pharmacy technicians. This would have a number of benefits including: clarity over the knowledge, skills and experience required at the different stages; awareness of education and training availability; and, enablement of professional development and advancement (Duggan 2010).

One of the Directors of Pharmacy talked about “almost the technician profession has an equal voice around the table about service redesign (Participant 2D, excerpt on page 174). Dowling et al. (2000) in their research into nursing and medical practice assert that nurses and medics should be equal partners in the development of new nursing roles to manage the risks surrounding accountability, scope of practice and any training required for new roles. It must be recognised that pharmacists and pharmacy technicians have a different education and training and therefore it is not just a case of shedding pharmacists’ roles onto pharmacy technicians. There is a lack of understanding amongst pharmacists of the pharmacy technician qualification, thus involving pharmacy technicians as equal partners in the design and development of new roles would provide education and strategic management to manage any risks around competency and accountability for the protection of patients and individual staff.

Whilst the Directors of Pharmacy reported that tensions amongst pharmacists related to pharmacy technicians' roles developing had lessened due to pharmacists' desire to develop their own roles, one said there remained a "small component of a small element" of the pharmacist workforce who were still reluctant. This was put down to possibly a lack of confidence or lack of understanding of pharmacy technicians training and experience. A lack of trust in pharmacy technicians was also highlighted in the report from the 'Optimising Pharmacy Skill Mix' workshop (Great Britain. Department of Health 2014) with the recommendation being that leadership is required to raise awareness of pharmacy technicians' skills and competencies but also that pharmacy technicians need to behave professionally to build this trust. The 'Optimising Pharmacy Skill Mix' report (Great Britain. Department of Health 2014) also noted that the current over-supply of pharmacists would probably add to the reluctance of pharmacists to relinquish roles to pharmacy technicians. Further, there was a call for clear accountability, which Participant 2D also identified as a requirement and which was discussed further in Section 4.2, Accountability.

Referring back to Anne Witz's (1992) social closure model, described in Section 2.6.3, the APTUK, as the professional leadership body for pharmacy technicians, can be considered to have employed a 'dual closure strategy' in relation to the current state of professionalisation of pharmacy technicians. Dual closure strategies comprise both exclusionary closure and usurpationary tactics. The APTUK's call for mandatory registration for pharmacy technicians is an exclusionary closure strategy, excluding those considered ineligible from

registering as a pharmacy technician. The usurpationary tactic involved an accommodative stance: promoting the delegation of tasks to pharmacy technicians based on a 'rigorous' risk management strategy (Association of Pharmacy Technicians UK 2011, 2013a) and the use of "robust" SOPs (Association of Pharmacy Technicians UK 2011, p.2). Therefore the pharmacy technician role advances but accepts 'control' by the 'dominant' profession of pharmacists. An alternative approach would be a 'revolutionary' stance (Witz 1992) which opposes 'subordination' and instead would involve the APTUK demanding changes to the education and training and promoting an increased scope of competence. This revolutionary approach would better enable pharmacy technicians to lead the development of their own professional practice.

4.8.4 Summary

It was reported that up to the present day, pharmacy technicians' roles had developed out of necessity to take on activities that pharmacists had divested themselves of so that their own roles could develop. However, pharmacy technician regulation and the need to further develop pharmacists' roles were identified as drivers to enable pharmacy technicians to further advance and to take more ownership of this.

Participants described the future pharmacy technician's role in terms of ward-based activities; barriers to achieving this were expressed as a lack of formal

training, a lack of confidence about, and amongst, pharmacy technicians, along with a lack of planning and sustainability.

One Director of Pharmacy described a desire for pharmacy technicians to be responsible for role development however, whilst not questioning the genuineness of this desire, rhetorical features illuminate the portrayal of pharmacists in a dominant position over pharmacy technicians. The other Director of Pharmacy warned pharmacy technicians against becoming too specialised on the basis of self-interest over developing roles in the best interests of the public.

In order to support pharmacy technicians to advance their own practice there should be a review of entry level training, the provision of a 'Scope of Professional Practice for Pharmacy Technicians' and clear accountability over roles for pharmacy technicians and pharmacists. The APTUK should consider taking a more 'revolutionary' stance in the development of pharmacy technician role, rather than promoting a risk management approach for delegated tasks with robust SOPs, which perpetuates the subordinate role of pharmacy technicians. In the meantime pharmacy technicians should be involved in any discussions about role development locally, considering the current entry level qualification. On the whole, regulation was said to support advancing practice for pharmacy technicians as it provides a governance framework and holds individuals accountable for their practice.

Linked to the characteristic of advancing practice is the advancement of knowledge, which is explored in the following section.

4.9 Excellence: Advancing Knowledge

4.9.1 Introduction

According to some commentators, the advancement of knowledge is another key characteristic of a profession (Beaton 2010; Johnson 1972; Lorentzon 1992; Sim and Radloff 2008; Witz 1992). The creation and development of new knowledge is usually associated with participation in research, however Eraut (1994) claims that knowledge can be created and developed by professionals in their field of practice but that this capability is under-exploited. Eraut (1994) explains the reasons for this being the individualistic nature of this knowledge development, with practitioners applying their new knowledge within their own practice but not communicating it to others. Therefore "there is no cumulative development of knowledge over time: the wheel is reinvented many times over" (Eraut 1994, p.56). To address this problem he asserts that researchers and practitioners need to work collaboratively but that this is not an easy solution to actualise.

4.9.2 Analysis: Advancing Knowledge

One Director of Pharmacy identified advancing knowledge as a key feature of a profession:

Participant 1D

So for me, it's not about an individual professional but what is a profession to some extent and a profession to me is a group that develops new knowledge that contributes to the advancement, advancement for the public. So I'm not talking about even just in terms of, about healthcare professionals but just generally, they, they, they develop new knowledge. And they have, the professions should, should in a sense house expertise and knowledge that you would not normally find elsewhere, which can be categorised according to what that group have, and that they work, that they should be working, again not just to serve their own needs but to use their knowledge and skills and ability to actually advance practice in some ways for the benefit of others.

Interviewer: OK so that's really have an expert knowledge and also then advancing that knowledge would you say?

Yes.

Interviewer: So, do you see pharmacy technicians meeting those two kind of categories then would you say?

... The advancing knowledge one I'm not so sure about. And, and actually I think the advancing knowledge is actually what almost gives you the right to call yourself a profession really, and so it's something in terms of developing a professional ethos that the group need. And I think it's true of lots of professions, I, I actually despair of pharmacy sometimes in terms of how good we are at advancing knowledge. So we do, but not as much as I would like us to do it. But I think, I think for, for technicians as a group, as a whole, that's a sign of the, that, that you're a new profession and that's something at least for me that you need to work on.

Page 1-2

Repetition in the first excerpt emphasises that the creation of new knowledge to advance practice has to be for the benefit of the public and not for self-interest. This Director of Pharmacy shifts the responsibility for developing knowledge to the profession as a group rather than individual professionals and how there is a need for pharmacy technicians to develop a "professional ethos" regarding the advancement of knowledge. However, she then concedes that "it's true of lots of professions" and that it's a sign that "you're a new profession". Lastly there is what could be considered defensive rhetoric

in the form of a three part concession (Antaki and Wetherell 1999): “I actually despair of pharmacy sometimes in terms of how good we are at advancing knowledge (the proposal). So we do (the concession), but not as much as I would like us to do it” (the reprisal).

4.9.3 Discussion

The Director of Pharmacy’s claim that advancing knowledge is the responsibility of the profession as a group led me to consider what the Association of Pharmacy Technicians UK (APTUK), as the professional leadership body for pharmacy technicians, has achieved or is undertaking in relation to this. The APTUK’s aims include “to maintain, safeguard and enhance the professional and educational standards of all pharmacy technicians” and “to improve educational standards (BTEC/SCOTVEC Qualification, NVQ/SNVQ National Occupational standards)” (Association of Pharmacy Technicians UK [no date] b). It is unclear what the second aim listed here adds to the first. In respect of these aims, the APTUK organises and holds an annual conference, and invites applications for three awards: pharmacy technician of the year award; outstanding contribution award; and, the Katherine Miles poster award. These activities can be seen to fall into the category of developing new knowledge as described by Eraut (1994) by sharing good practice and recognising innovation, patient care and leadership (Association of Pharmacy Technicians UK [no date] c). Recent Pharmacy Technician Journals are informative and promote patient-centred professionalism (Association of Pharmacy Technicians UK 2013b, 2014a,

2014b). Furthermore, in the Summer edition, an article by Patel (2014) promotes research in community pharmacy and the availability of 'Research Ready', an "online self-accreditation assessment" that "explains the basic requirements for undertaking primary care research in the UK and is aligned with the latest research governance frameworks" (p.5). This would appear a step in the right direction in supporting the advancement of knowledge for pharmacy technicians but it is limited and there is nothing on the APTUK website regarding supporting or funding pharmacy technician research. Personal email correspondence with the President of the APTUK (Fess, T. 2014. pers. comm., 23 June 2014) revealed that one piece of research regarding CPD had been carried out with the University of Hertfordshire in 2010 although this had not been published.

None of the pharmacy technicians interviewed had carried out research. Some had been involved in audits and had made improvements to practice which may be construed as meeting Eraut's (1994) description of developing new knowledge at a practice level rather than through research. However, as Eraut (1994) purported, this new knowledge is rarely shared. To help with this gap, as well as encouraging research, the APTUK could support and encourage 'communities of practice'. This term was coined by Wenger and is defined as "groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly" (Wegner-Trayner [no date]). Communities of practice comprise of three main elements: individuals share an interest and competence (the domain); members are

willing to actively participate in discussions and learn from each other (the community); and, members share resources and practices (the practice).

Whilst healthcare practitioners are expected to carry out research to create new professional knowledge and enhance services, it is arguable what level of practitioner should do this. Is it more beneficial and realistic for early year's practitioners to have a staged approach to training? From day one they develop their clinical skills through experience and completing further appropriate qualifications before then progressing to research at a more advanced role once they have consolidated their clinical skills. A staged approach to training building on the APTUK's foundation pharmacy framework (Anon. 2014b) could support this.

4.9.4 Summary

Advancing knowledge is considered a key characteristic of the professions (Beaton 2010; Johnson 1972; Sim and Radloff 2008; Witz 1992), but this is not an activity carried out by any of the pharmacy technician participants in this study. The APTUK whilst aiming to "enhance professional and educational standards for pharmacy technicians" (Association of Pharmacy Technicians [no date] b) does not actively support research activity amongst pharmacy technicians. As the leadership body for pharmacy technicians, the APTUK should provide access to research funding and encourage the development of communities of practice (Wenger-Trayner [no date]) to help share knowledge amongst pharmacy technicians.

5 CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The aim of this study has been to explore discourse on the regulation and professionalism of pharmacy technicians working in hospital pharmacy, and as a result I have identified policy, practice and education recommendations that will enable professional practice for pharmacy technicians.

Chapter 2, the Literature Review, highlighted that pharmacy technicians' roles in hospital have greatly developed over the last 20 years as pharmacy services modernised and pharmacists' roles became predominately clinical. 'Prescription for Excellence' the pharmacy strategy for Scotland (Scottish Government 2013a) requires further development of the pharmacy technician role into more patient-facing positions. As a result of government plans to regulate healthcare staff working directly with patients (Great Britain. Department of Health 2000), pharmacy technician registration with the GPhC eventually became mandatory in 2011 (Anon. 2009). An acknowledged benefit of regulation is professional recognition (Nicholls 2010) and consequently there is an expectation of professional behaviour from pharmacy technicians (Rudkin 2013). The need for professionalism amongst healthcare practitioners has been highlighted recently by two high profile reports: the Francis Inquiry (Mid Staffordshire NHS Foundation Trust 2013) and the Keogh (2013) review. Moreover, other healthcare professions have emphasised the requirement for caring, patient-centred professionalism (Scottish Government 2012). A review of the empirical literature identified a

gap in knowledge regarding pharmacy technicians and professional practice in general and particularly post-mandatory registration with the GPhC, and as a result the following two research questions were developed:

- How do pharmacy practitioners present pharmacy technicians in relation to contemporary professionalism characteristics?
- How do pharmacy practitioners account for roles and future practice development in light of pharmacy technician regulation?

This study utilised concepts from the sociology of the professions as the interpretative framework to explore the notion of professionalism in modern healthcare and whether or not pharmacy technicians are enabled to undertake professional practice for which they are now held accountable. In particular the analysis set out to draw upon Stern's (2006) principles of professionalism as fundamental aspects of professionalism in modern healthcare, along with the requirement for an underpinning specialised body of knowledge. The significance of closure strategies utilised by professions within the power approach and the use of credentialising for role development only became apparent as the analysis progressed, the sociology of the professions thus providing a way of understanding the data and enabling the development of some of the recommendations.

The methodology for this study was provided in Chapter 3, describing the social constructionist assumptions underpinning the research and the utilisation of a broad discourse analysis method to study how pharmacy

practitioners talk about pharmacy technicians and professionalism. The findings were presented in Chapter 4 under the main topic headings of accountability, a specialised body of knowledge, altruism, humanism and excellence.

The remainder of the present chapter commences with a section to situate the findings within a social constructionist paradigm followed by a synthesis of the empirical findings from this research. Thereafter I present theoretical implications including my contribution to knowledge, followed by policy, practice and education implications. There follows a section on reflection, highlighting what went well with the study and the lessons learned. The limitations of this study and the potential for further research are also described, and finally an overall conclusion completes this chapter and thesis.

5.2 The Findings as Constructed

Before presenting the key findings, contributions and implications of this research it is important to situate these within the social constructionist framework utilised for this study. Section 3.2 presented an overview of social constructionism whereby positivism, with its objective, value-free knowledge is rejected and instead knowledge is considered to be subjective, culturally and historically specific, sustained and constructed by language as social action and therefore knowledge varies dependent on the context.

Within the social constructionist paradigm it is clear that my account provided in this thesis is itself a construction: I have constructed a discourse on the discourse of my participants. Moreover, I use fact-construction devices, an academic writing style and references to literature in order to persuade the reader of the authenticity and trust-worthiness of my report. Nonetheless, this does not invalidate the participants' accounts (Burr 2003): the discourses and patterns in the data are there in the sense that they are latent potential readings and interpretations of the data. Indeed the data as a record of what was said is also a research production in that in order to analyse it a certain level of transcription had to be adopted (Potter 1996a). This itself makes the transcript an artefact, something that is produced as 'research output'. No non-verbal or paralinguistic features were recorded and yet these might have been germane to the interactions in the interviews. Thus the choices and decisions I made throughout this research have consequences for the findings (Harper 2006).

In Section 3.8 I drew attention to the central role of the researcher in social constructionist research: my discourse on the discourse of the participants is also a reflection of my own interest in the research. In other words, the research is not just about the participants, it is also about me, and it has led to further reflexivity on my part given my 'insider' position.

In Section 3.2 I also acknowledged the contested issue of generalisation and application of findings from research carried out within the social constructionist paradigm. Notwithstanding my critique of the notion of

generalisability, in relation to these issues I have taken a ‘subtle realist’ stance, accepting my findings as temporal, cultural and partial but applicable nonetheless (Hammersley 1992, cited in Taylor 2001b, p.325).

Warrantability is considered a fundamental requirement in the generalisation and application of discourse analysis findings and therefore I took a number of steps to ensure rigour and transparency in my method, analysis and reporting of findings, for example the provision of transcripts, explication of excerpt selection and categories used (see Section 3.9 and Appendix 25 for more details). Furthermore I presented my personal history and motivations in Section 1.3 and a section on reflexivity (Section 3.8) where I disclosed my orientations and efforts I took to manage my known subjectivities in order to orient the reader to my perspectives.

In summary, I acknowledge that my findings are constructed and that I offer a version which is historically and culturally specific, and one of a number of possible readings. Nonetheless, I utilised a strong rigour framework to help ensure that my account is well-founded and sound, making the case that my findings are applicable with implications for practice. As Stainton-Rogers (1991, p.10, quoted in Harper 2003, p.87) put it, I’m not “telling it like it is” but instead saying “look at it this way”.

The next section presents a synthesis of the key findings from this study, noting when a similar position was shared by the small number of other studies in the field.

5.3 Key Findings

The pharmacy technician profession is in its infancy, only being established as a 'recognised profession' upon plans for mandatory registration in 2011 (Anon. 2009). The empirical findings from this study illuminate the 'newness' of this emerging profession and, importantly, that the rhetoric about pharmacy technicians gaining professional recognition as a result of regulation is not adequately supported by current policy, practice or education. The empirical findings are synthesised below in relation to the two research questions.

Research Question 1: How do pharmacy practitioners present pharmacy technicians in relation to contemporary professionalism characteristics?

Pharmacy practitioner accounts portray pharmacy technicians as meeting some aspects of the contemporary professionalism attributes explored in this study, these being accountability, altruism, excellence and humanism, and the structural aspect of a specialised body of knowledge. Regarding the latter, pharmacy technicians can be considered to have a unique role with respect to the safe and secure supply chain of medicines, this finding later being substantiated by the vision laid out in 'Prescription for Excellence' (Scottish Government 2013a). Pharmacy technicians' unique role can therefore be considered to require specialised knowledge.

Participants' accounts, either explicitly or through analysis of discursive devices and features employed, suggest that not all pharmacy technicians are considered to have the professional attributes of accountability, altruism,

humanism and excellence. These reported 'gaps' in pharmacy technicians' professionalism are now examined, firstly in relation to actions that are considered within individual pharmacy technician's gift to address, and secondly, those that require action at a local or national level.

The findings from this study convey that pharmacy technicians at times presented themselves as passive; awaiting others to furnish them with projects for CPD or with information, and not taking a pro-active approach to their professional responsibility to be familiar with, and use, the 'Standards of conduct, ethics and performance' (General Pharmaceutical Council 2012a). Little value was attached to CPD and there was a lack of understanding of reflective practice, which was also a finding by Schafheutle et al. (2012). As discussed in Section 4.2, accountability is a fundamental characteristic of professionalism (General Pharmaceutical Council 2012a) but this study, in accordance with Bradley et al.(2013), illustrated an apprehension and lack of understanding about accountability. Participants reported a lack of altruism amongst some pharmacy technicians and a lack of willingness to challenge unprofessional behaviours. These are all individual attributes for which pharmacy technicians can take personal responsibility to develop.

However, these individual responsibilities are also linked to broader discourses and structures: it is difficult for pharmacy technicians to take accountability for their practice if they do not have sufficient autonomy and authority (Batey and Lewis 1982). A number of other commentators have called for clarification over accountability for pharmacy technicians and

pharmacists particularly where there is a blurring of roles (Bradley et al. 2013; Great Britain. Department of Health 2014; Middleton 2006; Pharmacy Law and Ethics Association 2014; Wingfield 2014). Moreover, traditional roles, particularly around getting work 'double checked', and traditional hierarchies within hospital pharmacy promote pharmacy technicians to assume subordinate roles to pharmacists, and while these continue to exist there will be challenges for pharmacy technicians to meet their professional responsibilities and accountabilities.

In addition to these individual and organisational features, and indeed a contributory factor, is the failure of the 'Standards for the initial education and training of pharmacy technicians' (General Pharmaceutical Council 2010a) to prepare pharmacy technicians for professional practice. Current education and training is not fit for purpose on two fronts; first, the content related to current roles and aspects of professionalism, as also identified by the National Acute Pharmacy Services group (2012) and Middleton (2007); and second, the level, which was also a finding by Herrera (2010) and Middleton (2006) in that the current replicative and applicative model stresses obedience and following orders.

Whilst pharmacy technicians are required to be pro-active in those aspects of professionalism over which they have control, to expect them to exercise professional judgement and make ethical decisions, have the confidence to raise concerns, advance practice and carry out research, when their

professional socialisation, in particular their education and training, and the infrastructure has not yet equipped them to do so is unrealistic.

Research Question 2: How do pharmacy practitioners account for roles and future practice development in light of pharmacy technician regulation?

Participants' accounts of future roles for pharmacy technicians centred on ward-based activities and regulation was acknowledged as supporting this advancement of practice as it provides a governance framework. However, considering the barriers that were presented by participants in terms of lack of accredited training for current extended roles, a lack of confidence amongst and about pharmacy technicians and insufficient planning and sustainability, regulation alone will not be enough to develop pharmacy technicians' roles in order to make best use of skills and to support delivery of the pharmacy strategy for Scotland as outlined in 'Prescription for Excellence' (Scottish Government 2013a).

The notion that certification is required for the 'extended role' into ward-based activities is limiting the development of this role throughout Scotland. This issue relates back to the unsuitability of the current qualification in preparing pharmacy technicians for professional practice and is hampered by the lack of clarity over accountability where the pharmacy technician and pharmacist roles are blurred.

Pharmacists were portrayed as the dominant profession with the Directors of Pharmacy reporting that up until now changes in pharmacy technicians' roles have been due to pharmacists' desire and leadership. Advancing practice is considered a core component of a profession in the power approach (Larson 1977; Witz 1992) and this need for pharmacy technicians to 'take ownership' of practice development was espoused by one Director of Pharmacy. However in order to do this, organisational structures and job descriptions need to reflect this responsibility, giving pharmacy technicians authority and autonomy to be accountable for their practice and for practice development. Pharmacy technicians then need to be prepared to accept this accountability and shift from a passive role into one that will challenge and develop. However this will also require pharmacists to shift from a dominant role into one that accepts pharmacy technicians as professionals in their own right.

The APTUK can be seen to have used an 'accommodative' strategy (Witz 1992) regarding practice advancement for pharmacy technicians, endorsing a rigorous risk management strategy and a requirement for robust SOPs to promote the 'delegation' of tasks (Association of Pharmacy Technicians UK 2011). An alternative approach would be a 'revolutionary' stance (Witz 1992) which opposes 'subordination' and instead would involve the APTUK demanding changes to education and training and promoting an increased scope of competence which could be achieved by developing a 'Scope of Professional Practice for Pharmacy Technicians'.

Advancing knowledge is another key characteristic of the professions (Beaton 2010; Johnson 1972; Lorentzon 1992; Sim and Radloff 2008; Witz 1992) but one that pharmacy technicians have little experience of and for which their education and training does not prepare them. The APTUK, whilst rewarding innovation that develops new knowledge and enabling the sharing of knowledge (Association of Pharmacy Technicians [no date] c), does not have a programme to support pharmacy technicians to undertake research.

In common with other commentators (Bradley et al.2013; Great Britain. Department of Health 2014; Middleton 2007), pharmacists' discourses revealed a dilemma about the role of pharmacists should pharmacy technicians take on roles they currently carry out. However since the interviews were held 'Prescription for Excellence' (Scottish Government 2013a) clearly identifies challenging future roles for hospital pharmacists to deliver pharmaceutical care to patients and thus it is time for pharmacists to focus on this role allowing distinct practice for pharmacy technicians and pharmacists.

5.4 Theoretical Implications

The discourse analytic approach taken and my 'insider' role have enabled me to report issues that may have been missed using a more positivistic approach, for example subtleties and complexities that were revealed by the interactional discourses. This research has shown that the rhetoric espoused

about pharmacy technician professionalism is not supported by current educational standards, policy or practice; furthermore, that there are gaps in key features of contemporary professionalism amongst pharmacy technicians, some of which pharmacy technicians themselves require to attend to but many that require changes at a local or national level in order to enable professional practice for pharmacy technicians.

As described in Chapter 2, the previous studies regarding pharmacy technician professionalism were carried out prior to mandatory registration (Middleton 2007; Schafheutle et al. 2012). Bradley et al.'s (2013) study into supervision in community pharmacy captured aspects of professionalism related to accountability and role development but has limited application due to its amalgamation of pharmacy technicians with pharmacy support staff when considering future role development. Moreover, none of the studies looked at the contemporary features of professionalism that appear relevant in modern healthcare. This is a timely piece of work given the renewed focus on professionalism (Keogh 2013; Mid Staffordshire NHS Foundation Trust 2013; Scottish Government 2012) and the demand for pharmacy technicians to extend their roles as set out in 'Prescription for Excellence' (Scottish Government 2013a), and to "focus on professionalism" in the best interests of patients (Rudkin 2013, p.3).

This study may be of interest to other newly registered professions particularly those in what was traditionally seen as a 'support' role, for example the dental

care professions. It may also be of interest to more established healthcare professions given the current focus on contemporary professionalism.

Regarding the approach taken for this study, I wish to make a case for the value of interview-based research in discourse analysis in contrast to Potter's (2012) recent shift to using naturally occurring talk instead. The interview method still yields valuable interpretations particularly when undertaken by an 'insider'; as an 'insider' I can continue to take a reflexive stance in actually doing the analysis. Furthermore, I argue for the value of discourse analysis in relation to practice-based research and its applicability, particularly to influence further understanding amongst practitioners. This research has led to further reflexivity on my part and I consider this is where the value of my work lies; by taking advantage of this reflexive knowledge I can promote a dialogue in the profession about professionalism. This will be done by reporting the findings back to pharmacy technicians to tease out the issues I have raised, to discuss implications for our practice and to help engender the reflective practitioner. Given that professionalisation is a dynamic process, this action research approach is an appropriate application of the findings from this study.

The findings of this study can also be used to inform changes to policy, practice and education in order to promote professionalism, and these are described in more detail in the following section.

5.5 Policy, Practice and Education Implications

An interest in this research has been expressed by Directors of Pharmacy in Scotland, the APTUK and the GPhC, and a report will be presented to them outlining in particular the recommendations to enable patient-centred professionalism amongst pharmacy technicians.

This research has analysed pharmacy practitioners' discourses drawing upon concepts from the sociology of the professions to explore if pharmacy technicians are equipped for professional practice, with the aim of influencing policy makers and practitioners to address any gaps. As a result a number of recommendations have been established, and the transfer of findings from this research has already begun. First I present the progress that has already been made that will facilitate pharmacy technicians taking responsibility to enhance their own professional practice, followed by recommendations required at a policy, national or local level.

Firstly the progress made thus far supports the engendering of professionalism from the point of recruitment and selection; I led the development of national guidance for Scotland on the recruitment and selection of pre-registration trainee pharmacy technicians, which included person specifications that identified essential professional attributes. This was ratified for use in Scotland by NAPS in August 2014.

Looking at broader aspects of professionalism, I proposed and have agreement to progress the development of a 'Professionalism Programme' for all pharmacy staff in my Health Board. This includes: values-based recruitment and induction; mandatory training for all staff and management on professional behaviours and raising and dealing with concerns; and, individual feedback on agreed behavioural criteria and personal development through the NHS electronic Knowledge and Skills Framework. Further, there is an interest at an organisational level in my Health Board to develop the concept of this programme for all healthcare staff. On presenting my professionalism programme to NAPS, group members identified a gap in awareness and education on professionalism in their Health Boards and a desire for a national programme based on my work. I met with the Director of Pharmacy at NES and the National Co-ordinator for Pharmacy Support Staff on 6th October 2014 to discuss progressing the professionalism programme at a national level.

At a local level I have also developed the terms of reference for a professional forum for pharmacy technician managers to provide a focus for professional leadership for pharmacy technicians and provide a consultation forum for professional issues to promote professional practice. To support professional development at a national level I have initiated discussions with senior pharmacy technician managers in Scotland to develop a Scottish professional forum for pharmacy technicians.

The policy, practice and education recommendations that will enable professional practice for pharmacy technicians are identified in Table 5-1 below:

Table 5-1 Policy, practice and education recommendations

Aim	Recommendation
POLICY	
To create conditions and provide opportunities for pharmacy technicians to demonstrate professional practice and contribute to delivery of Prescription for Excellence and the 2020 Vision for Health and Social Care.	Develop the pharmacy technician role to take responsibility for the safe and secure supply chain of medicines in accordance with the NAPS skill mix vision for acute hospital pharmacy.
	Pharmacists focus on the provision of pharmaceutical care which will aid clarity of accountability and a distinct role for the two pharmacy professions.
	Organisational structures and roles need to enable authority and autonomy so that pharmacy technicians are in a position to take accountability for their practice.
	Change discourses and practice to promote the two pharmacy professions as complementary rather than pharmacists in a dominant position.
PRACTICE	
To enable pharmacy technicians to develop their own professional practice and to aid clarification of accountability for pharmacy technicians and pharmacists.	Develop and implement a Scope of Professional Practice for Pharmacy Technicians to enable accountability and the development of extended roles without necessarily the need for certification.
	Involve pharmacy technicians at a local level when developing roles.
	The APTUK take on a more revolutionary role regarding practice advancement and support pharmacy technicians to establish communities of practice and to undertake high quality research.
	To implement and embed a 'Professionalism Programme' for all pharmacy staff to support patient-centred professionalism.
	To develop and implement a pharmacy technician professional forum in Scotland to support the professionalism agenda for pharmacy technicians.

Aim	Recommendation
EDUCATION	
To modernise pharmacy technician education and training to build confidence and equip pharmacy technicians with the knowledge and skills required for professional practice from day 1 onwards and through their careers to consultant level practice.	Update the Standards for Initial Education and Training of Pharmacy Technicians to include aspects of professionalism, namely: CPD and in particular reflective practice; the Standards of conduct, ethics and performance including ethical decision-making; accountability; altruism; and humanism.
	Update the Standards for Initial Education and Training of Pharmacy Technicians to include core roles for pharmacy technicians as identified by the NAPS skill mix vision, namely: medicines management roles and knowledge to build on for advanced clinical practice, and to be competent to carry out a final accuracy check of dispensed medicines from day 1 practice.
	The entry qualification needs to be of a level to prepare pharmacy technicians for professional practice in terms of preparation to work autonomously in an ever-changing environment, rather than a replicative and applicative model stressing obedience and compliance with Standard Operating Procedures. Furthermore this will provide an appropriate foundation for advancing practice to support innovation.
	Development of a staged training programme to support a career pathway, including research at the latter stages to promote advancing knowledge by the profession itself.

5.6 Reflection

Discourse analysis is a time-consuming and complex methodology and with hindsight two main aspects were underestimated: the amount of data that would be generated through the initial interview questions and the time it would take to carry out the discourse analysis. In large measure, as Potter and Wetherell (1987) acknowledge, discourse analysis is akin to learning to ride a bike: you can tell someone how to do it but there is no substitute for actually getting on the bike, wobbling a little, maybe falling off, climbing back on the saddle, and eventually getting the hang of it. In other words, it is something of an exercise in experiential learning and as an 'apprentice' researcher I have greatly enhanced my discourse analysis skills through *doing* analysis.

In future I will develop more specific themes for analysis prior to interview in an attempt to gather a more manageable data set, although as with many qualitative research methodologies there is nothing like getting amongst the data, reading and re-reading transcripts, until slowly an analysis is distilled from what can seem like a veritable mountain of data. It is also the case that research interviewing is not the same as other forms of interviewing. I will aim to improve my questioning technique to ask questions about the same issue in different ways throughout the interview in order to allow the potential for more variation in responses (Potter and Wetherell 1987; Wood and Kroger 2000). Notwithstanding these matters, the strengths of this research are related to my knowledge of pharmacy as an 'insider' and how discourse

analysis illuminated features of discourse to explore the research questions that would not have been possible through, for example, survey and content analysis.

5.7 Limitations

The known limitations of this study related to the methodology have previously been described in Chapter 3. The limitations that became apparent during the progress of this study were primarily regarding the focus on the contemporary attributes of professionalism and a specialised body of knowledge when data had been gathered in relation to broader theories and aspects of professionalism. As in many, if not all qualitative research projects, there is always the scope for more analysis and more interpretation. However, in order to maintain a manageable project it was necessary to limit the data used and therefore drawing on my 'insider knowledge' I selected aspects of professionalism that I considered important in modern healthcare. Further, this allowed more in-depth analysis by providing a clear and justifiable focus thus strengthening the findings.

Whilst acknowledging the amount of data gathered as a limitation, I have a body of transcribed data available for future research into the professionalisation of pharmacy technicians.

5.8 Recommendations for Future Research

The following recommendations for future research are made:

- Use the findings from this research as the basis for action research. This will enable a continued influence on education and training which has to keep pace with the professionalisation agenda for pharmacy technicians.
- Widen the sample of future research to include community pharmacy technicians with their different lived experiences.
- Discourse analysis of the remainder of the interview data gathered for this study to research other aspects of professionalism, for example professional socialisation, working relationships between pharmacy technicians and pharmacists, autonomy and descriptions of a 'good' technician.
- A discourse analysis of textual discourse including 'Prescription for Excellence' (Scottish Government 2013a) and the report from the 'Optimising Pharmacy Skill Mix' workshop (Great Britain. Department of Health 2014). This will allow a comparison between what is spoken and written about pharmacy technicians and professionalism in relation to the sociology of the professions.

5.9 Overall Conclusion

This research is informative, perhaps even a little controversial, as regards the professionalisation of pharmacy technicians. It has established that whilst the GPhC and pharmacy practitioners utter rhetoric about pharmacy technicians' professional recognition as a result of registration with the GPhC, the current standards for education and training, along with current discourse, practice and policy, do not support pharmacy technicians' professionalism. This is most definitely not to say that pharmacy technicians are unprofessional at present, but instead that there are gaps in our professional socialisation, some within our control but many not and which require leadership at a local and national level to address. This is perhaps to be expected given that pharmacy technicians are an emerging profession and professionalisation is a complex matter that is intertwined with other factors and allied work groups. Nonetheless, the recommendations made as a result of this study enable a pragmatic and patient-centred model of professionalism that will support delivery of 'Prescription for Excellence' (Scottish Government 2013a).

6 LIST OF REFERENCES

Anon. 2002. NPA calls on Society to halt plans for mandatory registration of technicians. *The Pharmaceutical Journal.* 269: p.203.

Anon. 2008. Scotland's community pharmacy representatives oppose plans to register and regulate technicians. *The Pharmaceutical Journal.* 280: p.353.

Anon. 2009. Statutory regulation of pharmacy technicians gets Privy Council approval. *The Pharmaceutical Journal.* 282: p.604.

Anon. 2013. GPhC embarks on three year project to evaluate pre-registration training. *The Pharmaceutical Journal.* 291: p.516.

Anon. 2014a. Rebalancing medicines legislation and regulation – update. *Regulate.* (13): p.7.

Anon. 2014b. The launch of the APTUK Foundation Pharmacy Framework. *Pharmacy Technician Journal.* Summer: p.41.

Antaki, C. et al. [no date]. *Discourse analysis means doing analysis: a critique of six analytical short comings.* [online]. Available from: http://extra.shu.ac.uk/daol/articles/v1/n1/a1/antaki2002002-paper.html [Accessed 15 August 2012].

Antaki, C. and Wetherell, M. 1999. Show concessions. *Discourse studies.* 1(1): p.7-27.

Association of Pharmacy Technicians UK [no date] a. *History of APTUK.* [online]. Available from: http://www.aptuk.org/about-us/ [Accessed 3 May 2014].

Association of Pharmacy Technicians UK. [no date] b. *Aims of the Organisation.* [online]. Available from: http://www.aptuk.org/about-us/ [Accessed 3 May 2014].

Association of Pharmacy Technicians UK. [no date] c. *Awards.* [online].Available from: http://www.aptuk.org/about-us/awards/ [Accessed 3 May 2014]

Association of Pharmacy Technicians UK. 2011. *Supervision – an enabler for modern patient centred pharmacy services.* [online]. Available from: http://www.aptuk.org/aptuk-news/2011/10/7/supervision-enabler-modern-patient-centred-pharmac/ [Accessed 13 May 2014].

Association of Pharmacy Technicians UK. 2013a. *APTUK position statement on pharmacy technicians supplying medicines through a PGD.* [online]. Available from:http://www.aptuk.org/aptuk-news/2013/8/18/aptuk-position-statement-pharmacy-technicians-supp/ [Accessed 13 May 2014].

Association of Pharmacy Technicians UK. 2013b. *Pharmacy Technician Journal.* Winter.

Association of Pharmacy Technicians UK. 2014a. *Pharmacy Technician Journal.* Spring.

Association of Pharmacy Technicians UK. 2014b. *Pharmacy Technician Journal.* Summer.

Audit Commission. 2001. *A spoonful of sugar. Medicines management in NHS hospitals.* London: Audit Commission.

Audit Scotland. 2009. *Managing the use of medicines in hospitals. A follow up report.* [online]. Available from: http://www.audit-scotland.gov.uk/docs/health/2009/nr_090416_managing_meds_supplement.pdf. [Accessed 7 April 2011].

Batey, M. and Lewis, F.1982. Clarifying autonomy and accountability. Part 1. Journal of Nursing Administration. September: pp.13-18. Quoted in: J. Savage and L. Moore. 2004. *Interpreting accountability. An ethnographic study of practice nurses, accountability and multidisciplinary team decision-making in the context of clinical governance.* London: Royal College of Nursing.

Batson, C.D. 1990. How social an animal: the human capacity for caring. American Psychologist. 45: pp. 336-346. Cited in: K.L. McCamant. 2006. Humanistic nursing, interpersonal relations theory, and the empathy-altruism hypothesis. *Nursing Science Quarterly.* 19: pp.334-338.

Beaton, G. 2010. *Why professionalism is still relevant.* [online]. Available from: http://www.professions.com.au/Files/Professionalism_Beaton.pdf [Accessed 23 February 2014].

Bell, J. 2005. *Doing your research project.* 4th ed. Berkshire: Open University Press.

Benson, A., Cribb, A. and Barber, N. 2009. Understanding pharmacists' values: a qualitative study of ideals and dilemmas in UK pharmacy practice. *Social Science and Medicine.* 68: pp.2223-2230.

Bloor, M. 1997. Addressing social problems through qualitative research. In: D. Silverman. ed. *Qualitative research: theory, method and practice.* London: Sage. 1997, pp.221-238. Cited in: Taylor, S. 2001b. Evaluating and applying discourse analytic research. In: M, Wetherell, S. Taylor and S, Yates. eds. *Discourse as data. A guide for analysis.* Milton Keynes: The Open University. 2001, pp.311-330.

Bottero, B. 1994. The changing face of pharmacy? Gender and explanations of women's entry to pharmacy. In: G. Harding, S. Nettleton and K. Taylor. *Social pharmacy. Innovation and Development.* London: The Pharmaceutical Press. 1994, pp.20-33.

Bowling, A. 1997. *Research methods in health. Investigating health and health services*. Buckingham: Open University Press.

Boynton and Greenhalgh. 2004. Selecting, designing and developing your questionnaire. *British Medical Journal.* 328: pp.1312-1315.

Bradley, F. et al. 2013. *Supervision in community pharmacy. Final report to Pharmacy Research UK.* Centre for Pharmacy Workforce Studies: Manchester Pharmacy School. [online]. Available from: https://www.escholar.manchester.ac.uk/uk-ac-man-scw:217320 [Accessed 24 May 2014].

Brown, P. and Levinson, S. 1987. Politeness: some universals in language usage. UK: Cambridge University Press. Cited in: L.A. Wood and R.O. Kroger. 2000. *Doing discourse analysis. Methods for studying action in talk and text.* London: Sage Publications Ltd.

Burr, V. 2003. *Social constructionism.* 2nd ed. East Sussex: Routledge.

Chaar, B., Brien, J.A.. and Krass, I. 2005. Professional ethics in pharmacy: the Australian experience. *International Journal of Pharmacy Practice*.13(3): pp.195-204.

Clarke, A.E. 2005. *Situational analysis. Grounded theory after the postmodern turn.* London: Sage Publications Ltd.

College of Paramedics. [no date]. *Paramedic Higher Education Programmes.* [online]. Available from: www.collegeofparamedics.co.uk/downloads/Paramedic_Higher_Education.pdf [Accessed 1 June 2014].

Cooper, S. 2005. Contemporary UK paramedical training and education. How do we train? How should we educate? *Emergency Medicine Journal*. 22: pp.375-379.

Coyler, H. M. 2004. The construction and development of health professions: where will it end? *Journal of Advanced Nursing.* 48(4): pp.406-412.

Cruess, R.L., Cruess, S.R. and Johnston, S. E. 2000. Professionalism: an ideal to be sustained. *Biomedical Reference Collection: Comprehensive*. 356 (9224): pp.156-159.

Day, P. and Klein, R. 1987. *Accountabilities: five public services.* London: Tavistock Publications Limited.

Donyai, P. et al. 2011. British pharmacy professionals' beliefs and participation in continuing professional development: a review of the literature. *International Journal of Pharmacy Practice.* 19: pp.290-317.

Dowling, R. et al. 2000. Nurses taking on Junior Doctors' work: a confusion of accountability. In: C. Davies, L. Finlay and A. Bullman. eds. *Changing practice in health and social care*. London: SAGE Publications Ltd. 2000, pp.326-334.

Duggan, C. 2010. Professional recognition in pharmacy: part 1 – demystifying the concepts. *The Pharmaceutical Journal.* 282: pp.592-593.

Edwards, D. and Fasulo, A. 2006. "To be honest": sequential use of honesty phrases in talk-in-interaction. Research on language and social interaction. 39: pp. 343-376. Cited in: A. Tseronis. 2011. Use and abuse of the strategic function of in fact and frankly when qualifying a standpoint. *Pragmatics.* 21(3): pp.473-490.

Edwards, D. and Potter, J. 1992. *Discursive Psychology.* London: Sage.

Elvey, R. et al. 2011. *Patient-centred professionalism among newly registered pharmacists.* Great Britain: Pharmacy Practice Research Trust.

Elvey, R., Hassell, K. and Hall, J. 2013. Who do you think you are? Pharmacists' perceptions of their professional identity. *International Journal of Pharmacy Practice.* 21(5): pp.322-332.

Eraut, M. 1994. *Developing professional knowledge and competence.* London: Routledge Falmer.

Etzioni, A. 1969. *The semi-professions and their organisation.* New York: The Free Press.

Evetts, J. 2012. Professionalism in turbulent times: changes, challenges and opportunities. In: *Propel International Conference.* Stirling, May 9-11. [online]. Available from: http://www.propel.stir.ac.uk/downloads/JuliaEvetts-FullPaper.pdf. [Accessed 28 March 2014].

Fairclough, N. 2010. *Critical discourse analysis: the critical study of language.* 2nd ed. Oxon: Routledge.

Ferguson J. 1999. Registration of technicians — the Society should opt out. *The Pharmaceutical Journal.* 263: pp.391-393.

Flick, U. 2014. ed. *An introduction to qualitative research.* 5th ed. London: SAGE Publications Ltd.

Freidson, E. 1970. *Professional dominance: the social structure of medical care.* New York: Atherton Press.

Gallagher, C.T. 2011. Assessment of levels of moral reasoning in pharmacy students at different stages of the undergraduate curriculum. *International Journal of Pharmacy Practice.* 19: pp.374-380.

General Dental Council. 2013. *Scope of practice.* [online]. Available from: http://www.gdc-uk.org/dentalprofessionals/standards/pages/standards.aspx [Accessed 6 June 2014].

General Pharmaceutical Council. [no date] a. *Education. Support Staff.* [online]. Available from: http://www.pharmacyregulation.org/education/support-staff [Accessed 31 May 2014].

General Pharmaceutical Council [no date] b. *Education. Pharmacy Technicians*. *Accredited Courses*. [online]. Available from: http://www.pharmacyregulation.org/education/pharmacy-technician/accredited-courses [Accessed 31 May 2014].

General Pharmaceutical Council [no date] c. *Pharmacy technician renewal and fitness to practise declarations.* [online]. Available from: http://www.pharmacyregulation.org/sites/default/files/pt_ftp_declarations_140826.pdf [Accessed 14 May 2014].

General Pharmaceutical Council. 2010a. *Standards for the initial education and training of pharmacy technicians*. [online]. Available from: http://www.pharmacyregulation.org/initial-PT [Accessed 31 May 2014].

General Pharmaceutical Council. 2010b. *Standards for continuing professional development.* [online]. Available from: http://www.pharmacyregulation.org/standards/continuing-professional-development [Accessed 31 May 2014].

General Pharmaceutical Council. 2011a. *Framework for continuing professional development.* [online]. Available from: http://www.pharmacyregulation.org/education/continuing-professional-development/cpd-framework [Accessed 7 June 2014].

General Pharmaceutical Council. 2011b. Continuing Professional Development. *Regulate.* (1): pp.16-17.

General Pharmaceutical Council. 2011c. *Plan and record. A guide to the GPhC's requirements for undertaking and recording continuing professional development.* [on-line]. Available from: http://www.pharmacyregulation.org/sites/default/files/gphc_plan_and_record_july_2011_version_ii._final.pdf [Accessed 7 June 2014].

General Pharmaceutical Council. 2012a. *Standards of conduct, ethics and performance.* [online]. Available from: http://www.pharmacyregulation.org/standards/conduct-ethics-and-performance [Accessed 31 May 2014].

General Pharmaceutical Council. 2012b. *Guidance on raising concerns.* [online]. Available from: http://www.pharmacyregulation.org/sites/default/files/GPHC%20Guidance%20on%20raising%20concerns.pdf [Accessed 31 May 2014].

General Pharmaceutical Council. 2013. *CPD frequently asked questions* [online]. Available from: http://www.pharmacyregulation.org/faq-page/54#t54n1079 [Accessed 13 April 2014].

Gergen, K. J. 1985. The social constructionist movement in social psychology. *American Psychologist.* 40.3: pp.266-275.

Gill, R. 1996. Discourse analysis: practical implementation. In: J.T.E Richardson, ed. *Handbook of qualitative research methods.* Leicester: RPS Books. 1996, pp.141-156.

Girot, E. A. 2000. Assessment of graduates and diplomats in practice in the UK – are we measuring the same level of competence? *Journal of Clinical Nursing.* 9(3): pp.330-336.

Goffman, E. 1981. *Forms of talk.* Oxford, UK: Basil Blackwell.

Great Britain. Department of Health.1994. *The Allit Inquiry: independent inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital during the period February to April 1991*. London: HMSO.

Great Britain. Department of Health. 2000a. *The NHS Plan: a plan for investment, a plan for reform.* London: Stationery Office.

Great Britain. Department of Health. 2000b. *Pharmacy in the future: implementing the NHS Plan.* London: Department of Health.

Great Britain. Department of Health. 2001. *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*. *[The Kennedy Report]*. London: Stationery Office.

Great Britain. Department of Health. 2007. *Trust, Assurance and Safety: the regulation of health professionals in the 21st century.* London: Department of Health.

Great Britain. Department of Health. 2010. *Responsibility and accountability best practice guide - moving on for new ways of working to a creative, capable workforce.* London: Department of Health.

Great Britain. Department of Health. 2014. Optimising Pharmacy Skill Mix. Joint RPS and APTUK Workshop*. Strategic overview and Rebalancing work.* London, January 16. Unpublished.

Great Britain. Working Party on the Hospital Pharmaceutical Service. 1970. *Report of the working party on the hospital pharmaceutical service.* London: HMSO.

Hallam, J. 2002. Vocation to profession: changing images of nurses in Britain. *Journal of Organizational Change Management.* 15(1): pp.35-48.

Hammer, D. P. 2000. Professional attitudes and behaviours: the "A's and Bs" of professionalism. *American Journal of Pharmaceutical Education.* 64(4): pp.455-465.

Hammersley, M. 1992. What's wrong with ethnography? Methodological explorations. London: Routledge. Cited in: S. Taylor, 2001. Evaluating and applying discourse analytic research. In: M, Wetherell, S. Taylor and S, Yates. eds. *Discourse as data. A guide for analysis.* Milton Keynes: The Open University. 2001, pp.311-330.

Harper, D. 1999. Tablet talk and depot discourse: discourse analysis and psychiatric medication. In: C. Willig, ed. *Applied discourse analysis. Social and psychological interventions.* Buckingham: Open University Press. 1999, pp.125-144.

Harper, D. 2003. Developing a critically reflexive position using discourse analysis. In: L. Finlay and B. Gough. eds. *Reflexivity. A practical guide for researchers in health and social sciences.* Oxford: Blackwell Science Ltd. 2003, pp.78-92.

Harper, D. 2006. Discourse analysis. In: M. Slade & S. Priebe. eds. *Choosing methods in mental health research: mental health research from theory to practice*. London: Routledge. 2006, pp.47-67.

Harrison. S. and Pollitt, C. 1994. *Controlling health professionals. The future of work and organization in the NHS.* Buckingham: Open University Press.

Health Act 1999. Section 60. [online]. Available from: http://www.legislation.gov.uk/ukpga/1999/8/section/60 [Accessed 29 August 2014]

Health Act. 2006. [online]. Available from: http://www.legislation.gov.uk/ukpga/2006/28/contents [Accessed 29 August 2014]

Health and Care Professions Council. 2014. *Standards for education and training guidance.* [online]. Available from: http://www.hcpc-uk.org/assets/documents/1000295EStandardsofeducationandtraining-fromSeptember2009.pdf [Accessed 10 May 2014].

Health Select Committee. 2011. *Health Committee publishes reports on healthcare regulators.* [online]. Available from: http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/11-07-26-nmcreportpublished/ [Accessed 5 May 2014].

Herrera, H. 2010. *Evaluation of a foundation degree for pharmacy technicians.* PhD thesis. University of Portsmouth.

Hertz, R. ed. 1997. *Reflexivity and Voice.* Thousand Oaks CA: Sage.

Hewitt, J. P. and Stokes, R. 1975. Disclaimers. *American sociological review*. 40: pp.1-11.

Hilton, S. R. and Slotnick, H. B. 2005. Proto-professionalism: how professionalisation occurs across the continuum of medical education. *Medical Education.* 39: pp.58-65.

Hockey, G. 2014. Regulation of other health professionals. In: G. Appelbe and J. Wingfield, eds. *Dale and Appelbe's Pharmacy and Medicines Law.* 10th ed. London: Pharmaceutical Press. 2014, pp.369-382.

Idis. [no date]. Pharmacy technicians' pharmacy education programme *Professionalism: an introduction to regulation*. Module 02.

Jefferson, G. 1991. List construction as a task and resource. In: G. Pasathas. ed. *Interaction Competence*. Lanham, MD: University Press of America. 1991, pp.63-92.

John, D. 2014. Pharmacy Regulation. In: G. Appelbe and J. Wingfield. eds. *Dale and Appelbe's Pharmacy and Medicines Law.* 10th ed. London: Pharmaceutical Press, 2014, pp. 303-324.

Johnson, T. 1972. *Professions and power.* London: The MacMillan Press Limited.

Keogh, B. 2013. *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. [online]. Available from: http://www.nhs.uk/NHSEngland/bruce-keogh review/Documents/outcomes/keogh-review-final-report.pdf [Accessed 11 October 2013].

Kilner, T. 2004. Educating the ambulance technician, paramedic, and clinical supervisor: using factor analysis to inform the curriculum. *Emergency Medicine Journal.* 21: pp.379-385.

Knipe, H. 2009. *Ask the technician.* [online]. Available from: http://www.pjcareers.com/article/ask-the-technician/ [Accessed 28 May 2014].

Knowles, M. 1984. *Andragogy in action. Applying modern principles of adult learning*. California: Jossey-Bass Publishers.

Langley, C.A. 2013. Pharmacy legislation: public protector or professional hindrance? *Medial Law Review.* 0(0): pp.1-22.

Larson, M. 1977. *The rise of professionalism. A sociological analysis.* London: University of California Press.

Leech, D. 2006. First year of registration – the challenges ahead for pharmacy technicians. *Hospital Pharmacist.* 13: pp.27-28.

Lorentzon, M. 1992. *Professionalism and professionalisation.* London: Distance Learning Centre.

Macdonald, K.M. 1995.*The sociology of the professions.* London: Sage Publications.

Marshall, T.H. 1939. The recent history of professionalism in relation to social structure and social policy. Canadian Journal of Economics and Political Science. Quoted in: T. Johnson,1972. *Professions and power.* London: The MacMillan Press Limited.

McCamant, K. L. 2006. Humanistic nursing, interpersonal relations theory, and the empathy-altruism hypothesis. *Nursing Science Quarterly.* 19: pp.334-338.

McGaghie. W.C. et al. 2002. Altruism and compassion in the health professions: a search for clarity and precision. *Medical Teacher.* 24(4): pp.374-378.

Medicines Act.1968. [online]. Available from: http://www.legislation.gov.uk/ukpga/1968/67/contents [Accessed 29 August 2014].

Middleton, H. 2006. What will it mean for technicians to be part of a profession? *Hospital Pharmacist.* 13: pp.411-412.

Middleton, H. 2007. What do technicians think about registration and professionalism? *Hospital Pharmacist.* 14: pp.100-102.

Millerson, G. 1964. The qualifying professions. London: Routledge & Kegan Paul. Cited in: T. Johnson. 1972. *Professions and power.* London: The MacMillan Press Limited.

Milligan, F. 1998. Defining and assessing competence: the distraction of outcomes and the importance of educational process. Nurse Education Today. 18: pp.273-280. Cited in: E. A. Girot. 2000. Assessment of graduates and diplomats in practice in the UK – are we measuring the same level of competence? *Journal of Clinical Nursing.* 9(3): pp.330-336.

Monrouxe, L. V., Rees, C. E. and Hu, W. 2011. Differences in medical students' explicit discourses of professionalism: acting, representing, becoming. *Medical Education.* 45: pp.585-602.

Moon, J. A. 2000. *Reflection in learning and professional development.* London: Routledge Ltd.

Morrow, S.L. 2005. Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology.* 52(2): pp.250-260.

Morse, J. and Field, P. 1996. *The application of qualitative research approaches*. 2nd ed. England: Clays Ltd.

Nairn, C. 2007. *What are pharmacy technicians' opinions on the proposed regulation of their profession and how can implementation be supported?* BSc dissertation. University of Abertay.

National Acute Pharmacy Services Group. 2012. *A review of the roles and responsibilities of pharmacy technicians and pharmacy support workers in the delivery of hospital services.* Unpublished.

Nicholls, B. 2010. The General Pharmaceutical Council and what it means for pharmacy technicians. In: *APTUK Annual Conference.* Cheshire, June 18-20. [online]. Available from: http://www.aptuk.org/media/dynamic/files/2010/10/27/Bob_Nicholls_CBE_pdf.pdf [Accessed 27 July 2014]

Nixon, A. and Power, C. 2007. Towards a framework for establishing rigour in a discourse analysis of midwifery professionalisation. *Nursing Inquiry*. 14(1): pp.71-79.

Nuffield Committee of Inquiry into Pharmacy. 1986. *Pharmacy: a report to the Nuffield Foundation.* London: Nuffield Foundation.

Oxford Dictionaries. 2013. Oxford University Press. [online]. Available from: http://oxforddictionaries.com/definition/english/profession [Accessed 8 September 2013]

Oxford Dictionaries. 2014. Oxford University Press. [online]. Available from: http://www.oxforddictionaries.com. [Accessed 11 May 2014]

Parsons. T.1939. The professions and social structure. *Social Forces.* 17(4): pp.457-467.

Patel, P. 2014. A leadership opportunity for pharmacy technicians: is your community pharmacy read for research? *Pharmacy Technician Journal.* Summer: p.5.

Pharmacy Law and Ethics Association. 2014. It wasn't me! Accountability in the healthcare team. *Study day.* Charles Russell solicitors, London, May 20. [online]. Available from: http://www.plea.org.uk/content/PLEA%20Prog%20May%202014%20webdraft.pdf [Accessed 18 May 2014].

Pollard, K.C. 2011. How midwives' discursive practices contribute to the maintenance of the status quo in English maternity care. *Midwifery.* 27: pp.612-619.

Pomerantz, A. 1986. Extreme case formulations: a way of legitamizing claims. *Human Studies*. 9: pp.212-229.

Pope, C. and Mays, N. eds. 2006. *Qualitative Research in Health Care.* 3rd ed. London: BMJ Books.

Potter, J. 1996a. Discourse analysis and constructionist approaches: theoretical background. In: J.T.E Richardson, ed. *Handbook of qualitative research methods.* Leicester: RPS Books. 1996, pp.125-140.

Potter, J. 1996b. *Representing reality: discourse, rhetoric and social construction.* London: Sage.

Potter, J. 2012. Re-reading discourse and social psychology: transforming social psychology. *British Journal of Social Psychology.* 51(3): pp.436-455.

Potter and Wetherell. 1987. *Discourse and social psychology: beyond attitudes and behaviours.* London: SAGE Publications.

Professional Standards Authority for Health and Social Care. [no date]. *Our work.* [online]. Available from: http://www.professionalstandards.org.uk/about-us/our-work [Accessed 10 May 2014].

Rafferty, A. M. 1996. *The politics of nursing knowledge.* London: Routledge.

Rennie, I., Nichol, H. and Carmichael, J. 2007. Morals or ethics: which would you rely on? *British Journal of Healthcare Assistants.* 1(8): pp.372-374.

Robinson, J., Strong, P. and Elkan, R. 1989. Griffiths and the nurses: a national study of CNAs. Nursing Policy Studies 4, Nursing Policy Studies Centre. University of Warwick: p.65. Quoted in: M. Lorentzon. 1992. *Professionalism and professionalisation.* London: Distance Learning Centre.

Royal College of Physicians. 2005. *Doctors in society. Medical professionalism in a changing world.* Suffolk: The Lavenham Press Ltd.

Royal Pharmaceutical Society. *History of Pharmacy*. [no date] a. [Online]. Available from: http://www.rpharms.com/about-pharmacy/history-of-pharmacy.asp [Accessed 27 May 2014].

Royal Pharmaceutical Society. *History of the Society*. [no date] b. [online]. Available from: http://www.rpharms.com/museum-pdfs/history-of-the-society.pdf (Accessed 27 May 2014].

Royal Pharmaceutical Society of Great Britain. 1996. *Pharmacy in a new age: the new horizon.* London: The Royal Pharmaceutical Society of Great Britain.

Royal Pharmaceutical Society of Great Britain. 2003. Society to proceed with regulation of technicians. *Pharmaceutical Journal.* 270: p.663.

Royal Pharmaceutical Society. 2013. *Now or never: shaping pharmacy for the future.* London: The Royal Pharmaceutical Society.

Rudkin, D. 2013. Focus on professionalism, pharmacy technicians told. *Regulate.* (11): p.3.

Saks, M. 1999. The wheel turns? Professionalisation and alternative medicine in Britain*. Journal of Interprofessional Care*. 13(2): pp.129-138.

Sandberg, J. 2005. How do we justify knowledge produced within interpretive approaches? *Organizational Research Methods.* 8(1): pp.41-68.

Savage, J. and Moore, L. 2004. *Interpreting accountability. An ethnographic study of practice nurses, accountability and multidisciplinary team decision-making in the context of clinical governance.* London: Royal College of Nursing.

Schafheutle. E. I. et al. 2012. Pharmacy technicians' views of learning and practice. *International Journal of Pharmacy Practice*. 20: pp.141-147.

Scottish Executive. 2002. *The Right Medicine: a strategy for pharmaceutical care in Scotland.* Edinburgh: The Stationery Office.

Scottish Government. 2012. *Professionalism in nursing, midwifery and the allied health professions in Scotland: a report to the Coordinating Council for the NMAHP Contribution to the healthcare Quality Strategy for Scotland.* Edinburgh: The Scottish Government.

Scottish Government. 2013a. *Prescription for Excellence. A vision and action plan for the right pharmaceutical care through integrated partnerships and innovation.* Edinburgh: The Scottish Government.

Scottish Government. 2013b. *Everyone matters: the 2020 workforce vision.* [online]. Available from: http://www.scotland.gov.uk/Publications/2013/06/5943/0 [Accessed 3 June 2014].

Scottish Office. 1994. *Project on Clinical Pharmacy Services*. Edinburgh: Scottish Health Management Efficiency Group/Clinical Research and Audit Group.

Scottish Qualifications Authority. 2013. *Arrangements document. HNC pharmacy services development and management. (G8015).* [online]. Available from: http://www.sqa.org.uk/files_ccc/HNCPharmacyArrangementsv1.pdf [Accessed 6 June 2014]

Shirley, J.L. and Padgett, S.M. 2010. Professionalism and disclosure: but wait, there's more! *The American Journal of Bioethics.* 4(2): pp.36-38.

Silverman, D. 2010. *Doing qualitative research.* 3rd ed. London: SAGE Publications Limited.

Sim, J. and Radloff, A. 2008. Profession and professionalisation in medical radiation science as an emergent profession. *Radiography.* 15: pp.203-208.

Southon, G. and Braithwaite, J. 2000. The end of professionalism? In C. Davies, L. Finlay and A. Bullman. eds. *Changing practice in health and social care.* London: SAGE Publications Ltd. 2000, pp. 300-307.

Stainton-Rogers, W. 1991. Explaining health and illness: an exploration of diversity. London: Harvester Wheatsheaf. Quoted in: Harper, D. 2003. Developing a critically reflexive position using discourse analysis. In: L. Finlay and B. Gough. *A practical guide for researchers in health and social sciences.* Oxford: Blackwell Science Ltd. 2003, pp.78-92.

Stern, D.T. 2006. *Measuring medical professionalism.* New York: Oxford University Press.

Stiles, W. B. 1993. Quality control in qualitative research. *Clinical Psychology Review.* 13: pp.593-618.

Taylor, K, Nettleton, S. and Harding, G. 2003. *Sociology for pharmacists.* 2nd ed. London: Taylor and Francis.

Taylor, S. 2001a. Locating and conducting discourse analytic research. In: M, Wetherell, S. Taylor and S, Yates. eds. *Discourse as data. A guide for analysis.* Milton Keynes: The Open University. 2001, pp.5-48.

Taylor, S. 2001b. Evaluating and applying discourse analytic research. In: M, Wetherell, S. Taylor and S, Yates. eds. *Discourse as data. A guide for analysis.* Milton Keynes: The Open University. 2001, pp.311-330.

The Mid Staffordshire NHS Foundation Trust. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* 2013. [online]. Available from: http://www.midstaffspublicinquiry.com/ [Accessed 25 February 2013].

The Pharmacy Order. 2010. [online]. Available from: http://www.legislation.gov.uk/ukdsi/2010/9780111487358/contents [Accessed 29 August 2014].

The Shipman Inquiry. 2005. *Sixth Report – Shipman: The Final Report.* [online]. Available from: http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/finalreport.asp [Accessed 1 August 2014].

Traulsen, J.M. and Bissell, P. 2004. Theories of professions and the pharmacist. *International Journal of Pharmacy Practice.* 12(2): pp.189-206.

Turnbull, W. and Saxton, K.L. 1997. Modal expressions as facework in refusals to comply with requests: I think I should say 'no' right now. Journal of Pragmatics. 27: pp.145-181. Cited in: L. Wood and R. O. Kroger. 2000. *Doing discourse analysis: methods for studying action in talk and text.* London: SAGE Publications Limited.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. 1992. *The Scope of Professional Practice.* London: UKCC.

Van de Camp, K. et al. 2004. How to conceptualize professionalism: a qualitative study. *Medical Teacher.* 26(8): pp.696-702.

Walsh, A. 2012. Who benefits from having pharmacy technicians in more advanced roles? *Clinical Pharmacist.* 4: pp.246-247.

Wenger-Trayner, E. [no date]. *Communities of practice. A brief introduction.* [online]. Available from: http://wenger-trayner.com/theory/ [Accessed 19 June 2014].

Weiss-Gal, I. and Welbourne, P. 2008. The professionalisation of social work: a cross-national exploration. *International Journal of Social Welfare.* 17: pp.281-290.

Wetherell, M, Taylor, S. and Yates, S. J. 2001. eds. *Discourse as data. A guide for analysis.* Milton Keynes: The Open University.

Widdicombe, S. and Wooffitt, R. 1990. 'Being' vs. 'doing' punk: On achieving authenticity as a member. *Journal of Language and Social Psychology*. (9): pp.257-277.

Wilensky, H.1964. The professionalisation of everyone. American Journal of Sociology. 70: pp.137-148. Cited in: T. Johnson.1972. *Professions and power.* London: The MacMillan Press Limited.

Willig, C. 1999. *Applied discourse analysis. Social and psychological interventions.* Buckingham: Open University Press.

Willig. C. 2014. Interpretation and analysis. In: U. Flick, ed. *The SAGE handbook of qualitative research*. London: SAGE Publications Ltd. 2014, pp.136-150.

Wingfield, J. 2011. Registered pharmacy technicians are accountable for what exactly? *The Pharmaceutical Journal.* 287: pp.246-247.

Wingfield, J. 2014. Pharmacists should delegate without fear. *The Pharmaceutical Journal.* 293: pp.115-116.

Wittgenstein, L. 1974 [orig.1958]. *The Blue and Brown Books: Preliminary Studies for the 'Philosophical Investigation': Preliminary Studies for the Philosophical Investigations.* Oxford: Blackwell.

Witz, A. 1992. *Professions and patriarchy.* London: Routledge.

Wodak, R. 2013. *Critical discourse analysis.* London: SAGE Publications Ltd.

Wood, L. and Kroger, R. O. 2000. *Doing discourse analysis: methods for studying action in talk and text.* London: SAGE Publications Limited.

Wooffitt, R. 2001. Researching psychic practitioners: conversation analysis. In: M, Wetherell, S. Taylor and S, Yates. eds. *Discourse as data. A guide for analysis.* Milton Keynes: The Open University. 2001, pp.49-92.

Wooffitt, R. 2005. *Conversation analysis and discourse analysis. A comparative and critical introduction.* London: SAGE Publications Ltd.